Supreme Court, U.S.
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No. 06-614

IN THE

Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

Petitioner,

—against—

MERIT BEHAVIORAL CARE CORPORATION, SATI AHLUWALIA, M.D. and EMPIRE BLUE CROSS AND BLUE SHIELD,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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Questions Presented for Review

This is a respectful request to the Justices of this Court to correct the 5-4 majority opinion in *Mertens v. Hewitt*, 508 U.S. 248 (1993) which is now in direct conflict with the Court's decision in *Aetna v. Davila*, 542 U.S. 200 (2004), prohibiting actions at law for injuries under ERISA.

1. Does Justice Story's 1836 treatise on Equity Jurisprudence show that the 5-4 majority opinion in *Mertens v. Hewitt*, 508 U.S. 248 (1993) omitted a key exception to the unavailability of monetary damages as an equitable remedy – the absence of "an adequate remedy at law"?

2. Does this court's subsequent 2004 decision in *Aetna v. Davila*, 542 U.S. 200 (2004), trigger that key exception by barring any adequate legal remedy under ERISA for injured beneficiaries?

3. As interpreted by *Mertens*, does ERISA allow health insurers to take "fraudulent advantage of the injured party" – in Justice Story's words – through bad faith denials of medically necessary care, and should *Mertens* now be modified and the judgment below be reversed to allow plaintiff to seek monetary damages against respondents?

TABLE OF CONTENTS

	Page
Questions Presented for Review	i
Table of Cited Authorities	iv
Opinions Below	1
Jurisdiction	1
Statute Involved	1-2
Statement of the Case	2
About the Case	2
The Facts	4
Detailed Allegations in the Complaint	6
Procedural History	8
ARGUMENT	
WHY CERTIORARI SHOULD BE GRANTED	11
1. JUSTICE JOSEPH STORY'S 1836 TREATISE ON EQUITABLE JURISPRUDENCE SHOWS THAT THE 1993 5-4 MAJORITY OPINION IN *MERTENS V. HEWITT* MISCONSTRUED THE PURPORTED UNAVAILABILITY OF COMPENSATORY DAMAGES AS AN EQUITABLE REMEDY AGAINST FIDUCIARIES DURING THE TIME OF THE DIVIDED BENCH	11

		Page
2.	*AETNA v. DAVILA* FIRMLY CLOSED THE DOOR ON LEGAL REMEDIES FOR INJURED ERISA BENEFICIARIES, AND SIMULTANEOUSLY PROVIDED THE BASIS FOR OPENING THE DOOR TO EQUITABLE COMPENSATORY DAMAGES	13
	No Adequate Remedy at Law	14
	Medical Necessity Determinations Are Fiduciary Decisions	15
	Historically, Equity Has Required a Fiduciary Who Violates His Duties to "Repair All The Damages"	15
3.	ERISA, AS PRESENTLY INTERPRETED BY THIS COURT, ALLOWS HEALTH INSURERS TO TAKE "FRAUDULENT ADVANTAGE OF THE INJURED PARTY" (JUSTICE STORY'S WORDS)	17
CONCLUSION		21
APPENDIX		

TABLE OF CITED AUTHORITIES

	Page
Cases	
Aetna Health, Inc. v. Juan Davila, 542 U.S. 200 (2004)	Passim
Cicio v. Does, 321 F.3d 83 (CA2 2003)	9
Cigna Healthcare of Texas, Inc. v. Ruby R. Calad, etal, 542 U.S. 200 (2004)	13
DiFelice v. Doe, 346 F.3d 442 (3rd Cir., 2003)	17
Mertens v. Hewitt, 508 U.S. 248 (1993)	Passim
Pegram v. Herdrich, 530 U.S. 211 (2000)	15
Pratt v. Law, 9 Cranch, 493	13, n. 3
Statutes and Regulations	
28 U.S.C. Section 1254(l)	1
28 U.S.C. Section 1291	2
28 U.S.C. Section 1331	2
29 U.S.C Section 1132 (ERISA Section 502(a)(3))	Passim

	Page
New York Insurance Law Section 4900	5, n.1
Public Health Law Section 4900	5, n.1

Other Authorities

Adams, John. The Doctrine of Equity: Being a Commentary on the Law as Administered in the Court of Chancery (Philadelphia, 1850)	16
Ballow, Henry. A Treatise on Equity, (London, 1737)	15
Fonblanque, John (Ed.) A Treatise on Equity, (Dublin, 1795)	16
Langbein, John H. What ERISA Means by 'Equitable': The Supreme Court's Trail of Error in *Russell, Mertens* and *Great-West*, 103 Columbia L. Rev. 1317 (2003)]	4
Story, Joseph. Commentaries in Equity Jurisprudence as Administered in England and America (1st ed., 1836)	Passim

OPINIONS BELOW

The full text of the Second Circuit order and opinion is set forth in the Appendix at page A-2.

Citations to official and unofficial reports of the opinions and orders entered in this case by Courts are as follows:

2006 WL 2381776 (C.A. 2 (N.Y.))
2005 WL 2249750 (S.D.N.Y.)
121 Fed. Appx. 414, 2005 WL 229862
(C.A.2 (N.Y.))
2003 WL 22019833 (S.D.N.Y.)
60 Fed. Appx. 887, 2003 WL 1913131
(C.A.2 (N.Y.))
2001 WL 1415165 (S.D.N.Y.)
163 F. Supp. 2d 227 (S.D.N.Y., 2001)

JURISDICTION

The order and judgment of the Court of Appeals was entered on August 14, 2006. Jurisdiction to review the order and judgment in question is conferred by 28 U.S.C. § 1254(1)

STATUTE INVOLVED

29 USC § 1132 (ERISA § 502(a)(3))

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought -- ***

(3) by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

STATEMENT OF THE CASE

This petition is based on (1) Justice Joseph Story's explanation of compensatory damages in courts of equity; (2) the plain conflict between this Court's *Mertens* and *Davila* decisions; and (3) powerful pleas for a more just and common sense interpretation of ERISA Section 502(a)(3) from scholars and Circuit Judges.

During the time of the divided bench, Courts of Equity awarded compensatory damages *when an adequate remedy was not available in courts of law* – as is now the case under ERISA. The members of the Court are respectfully urged to correct this erroneous omission in *Mertens* now and not wait until after years of needless hardship on working people and their families who depend on employee health benefit plans to provide adequate and competent health care.

About this Case

Subject matter jurisdiction in the District Court was based on 28 U.S.C. Sec. 1331. Appellate jurisdiction in the Court of Appeals was based on 28 U.S.C. Sec. 1291.

This litigation is a battle-scarred veteran of the long judicial search for an ERISA remedy to permit

beneficiaries to seek compensatory damages against employee health plan administrators who improperly overrule treating physicians in the provision of patient care. Over the past six years, plaintiff's counsel have attempted to follow various well-intended judicial efforts to find a way to protect group health plan beneficiaries – as Congress said it intended when it enacted ERISA – a goal that the Supreme Court has so far prevented. This is plaintiff's third appeal from dismissal of his claim in the District Court, all attempting to follow the changing judicial interpretations of ERISA.

Fortunately, this plaintiff reserved the right throughout the litigation to seek damages as an "appropriate equitable remedy" under ERISA Section 502(a)(3) and it is that issue that is now the present engine that drives this case.

Following this Court's 2004 decision in *Aetna v. Davila*, plaintiff filed a Second Amended Complaint in the Southern District of New York detailing his claim of breach of fiduciary duty against defendants and seeking monetary damages under 502(a)(3). The District Judge who had previously approved a similar remedy in a case involving different facts under the same section of ERISA, but was later reversed by the Second Circuit, felt bound to dismiss Eric Rubin-Schneiderman's complaint as a matter of law. The Court of Appeals impliedly suggested that this plaintiff seek leave to present the question to this Court.

Petitioner urges the Justices to re-address the erroneous 5-4 holding in *Mertens v. Hewitt*, 508 U.S. 248 (1993). Such action is supported by the history of damages in courts of equity and by a groundswell of judicial and scholarly outcry against the majority ruling in *Mertens*, not only by the four original dissenters (Justices White,

Rehnquist, Stevens and O'Connor), but also by such respected judicial voices as Judges Calabresi (2nd Circuit) and Becker (3rd Circuit) and most recently by Justices Ginsburg and Breyer in *Davila*, as well as the country's leading ERISA scholar, John H. Langbein of Yale Law School. [Langbein, What ERISA Means by 'Equitable': The Supreme Court's Trail of Error in *Russell, Mertens* and *Great-West*, 103 Columbia L. Rev. 1317 (2003)]

The Facts

At the time this action first arose, plaintiff was a young man suffering from a debilitating psychiatric illness that caused dangerously self-destructive thoughts and behavior. When he sought admission to an in-patient mental health care facility, the insurance company's mental health care manager misdiagnosed the severity of his condition and recommended an inappropriate out-patient course of treatment – a decision that eventually led to plaintiff's attempted suicide.

Defendants are Empire Blue Cross and Blue Shield, the administrator of plaintiff's health plan; Merit Behavioral Care Corporation, the mental health care manager for plaintiff's plan; and Dr. Sati Ahluwalia, a physician employee of Merit. It was Dr. Ahluwalia who made the erroneous determination that plaintiff's condition was treatable by out-patient therapy, rather than the more expensive in-patient treatment recommended by plaintiff's personal psychiatrist and approved by the admitting physician at the in-patient institution.

Dr. Ahluwalia's medical treatment recommendation was made during pre-treatment "utilization review" performed by Merit Behavioral Care Corporation ("MBC")

as agent for defendant Empire Blue Cross and Blue Shield ("EBCBS"), plaintiff's group health insurer.[1]

Plaintiff's health plan was Empire's "Blue Choice PPO" contract. That plan provides that while Empire was the administrator for all benefits except mental health and behavioral care, Merit performed the functions of plan administrator on Empire's behalf for the plan's mental health and behavioral care benefits, and was therefore an ERISA fiduciary. The plan provisions specify that a beneficiary cannot receive mental health and behavioral care benefits without Merit's advance approval. Merit's health care responsibility is described in the plan documents as follows:

> Your BlueChoice PPO benefits also include a behavioral health care management program. Like our Utilization Management Program, this program is designed to provide you with the highest quality of mental health and substance abuse care in the most appropriate setting.
>
> (A - 17) (Emphasis added.)

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[1] New York Ins. Law Sec. 4900 and Public Health Law Sec. 4900 define "utilization review" as:

> The review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. (Emphasis added.)

Detailed Allegations in the Complaint

In August, 1997, plaintiff's treating psychiatrist, Dr. Samuel C. Klagsbrun, determined that plaintiff should be admitted to Four Winds Hospital, an in-patient psychiatric facility in Katonah, New York. On September 5, 1997, plaintiff's father, David Schneiderman, spoke by telephone with Merit's Mental & Nervous Disorders Inpatient Division. He was informed that Merit's pre-approval of plaintiff's inpatient treatment at Four Winds Hospital was required in order to receive coverage under the BlueChoice PPO contract and that plaintiff was required to undergo a pre-admission psychiatric evaluation.

On September 8, 1997, plaintiff underwent a pre-admission psychiatric evaluation at Four Winds Hospital. On the same day, plaintiff applied to defendant Merit for preauthorization approving his admission to Four Winds Hospital and his inpatient treatment at that facility. The application process consisted primarily of telephone conversations between Merit employees and the Four Winds evaluating physician.

Despite plaintiff's acute psychiatric condition and the recommendation of his treating physician and of Dr. Jose Freire, the evaluating physician at Four Winds, Merit medical personnel verbally denied plaintiff's application for admission to Four Winds Hospital over the telephone.

In a follow-up letter to plaintiff dated September 9, 1997, Merit physician-advisor Sata Ahluwalia, M.D. stated that "Merit Behavioral Care determines the medical necessity of mental health and substance abuse treatment to beneficiaries of Blue Cross and Blue Shield," and then stated that "MBC cannot authorize inpatient psychiatric treatment at Four Winds Hospital" because "[b]ased on

information given, the current level of symptoms can be treated at a lower level of care. Recommendation is for an intensive outpatient program." No reason was given, only the result.

At no time did Dr. Ahluwalia or any other Merit or Empire physician or employee examine or evaluate plaintiff in person prior to determining that inpatient treatment was purportedly not medically necessary to treat plaintiff's psychiatric disorder.

At no time did Dr. Ahluwalia or any other Merit or Empire physician or employee interview plaintiff, even telephonically, prior to determining that inpatient treatment was purportedly not medically necessary to treat his psychiatric disorder.

Plaintiff's complaint alleges upon information and belief, that at no time did Dr. Alhuwalia or any other Merit or Empire physician or other employee examine plaintiff's medical and psychiatric records prior to determining that inpatient medical treatment was purportedly not medically necessary for treating his psychiatric disorder.

Subsequent events proved that, contrary to Merit's utilization review determination, the treating physician's recommendation of inpatient treatment for plaintiff at Four Winds Hospital was medically necessary and essential for the proper treatment of plaintiff's psychiatric disorder.

On April 6, 1998, plaintiff attempted to commit suicide by ingesting a large overdose of pills and medications. He was fortuitously discovered at the brink of death by his father who had him rushed to St. Luke's-Roosevelt Hospital where plaintiff received critical care for several hours in the Emergency Room. Medical personnel

intubated plaintiff and put him on life support. After receiving life-saving medical treatment, plaintiff was transferred to the Intensive Care Unit. Three days later, on April 9, 1998, he was transferred by ambulance to Four Winds Hospital for in-patient treatment in an extremely despondent mental state. As a result of this episode, plaintiff alleges that he has suffered permanent injury to his mental health and future well-being.

Procedural History

Plaintiff originally commenced this action on September 29, 2000 by filing a complaint in New York State Supreme Court. The Complaint alleged negligence on behalf of Merit and Ahluwalia and negligent hiring and supervision on the part of Merit and Empire. By Notice of Removal dated October 23, 2000, all three defendants removed the action to the United States District Court.

Plaintiff filed a timely motion to remand the case to New York State Supreme Court. By opinion and order dated April 9, 2001, the District Court (Martin, J.) denied plaintiff's remand motion, finding that plaintiff's claims based on negligent refusal to authorize treatment were subject to federal jurisdiction under the doctrine of complete preemption and that the remaining claims for negligent hiring and supervision were subject to the Court's supplementary jurisdiction.

Thereafter, plaintiff filed his first Amended Complaint realleging his state law claims, and adding additional ERISA claims.

Defendants moved to dismiss the Amended Complaint, and by Opinion and Order dated November 13, 2001, the District Court granted defendants' motion to

dismiss. The District Court found that plaintiff's state law claims were preempted by the ERISA statute and that the ERISA causes of action failed to state a claim for which relief could be granted.

Plaintiff's first appeal from the two District Court decisions resulted in a summary Order in the Court of Appeals vacating the judgment of dismissal and remanding the case for reconsideration in light of its recent *Cicio* decision. That order was filed April 18, 2003. The District Court then invited motions from the parties. Plaintiff renewed his motion to remand; Dr. Ahluwalia renewed her motion to dismiss; and Empire filed a motion for summary judgment.

On August 27, 2003, the District Court (Martin, J.) filed an Opinion and Order adhering to its earlier dismissal. A final judgment of dismissal was filed on October 27, 2003. Plaintiff appealed once again to the Court of Appeals. While that appeal was pending, the Supreme Court filed its decision in *Aetna v. Davila*, 542 U.S. 200 (2004), which addressed the same core issues then pending in this case, and holding that all claims for injuries were preempted by ERISA.

The Court of Appeals then remanded the case once again, this time to permit plaintiff to request leave to file a Second Amended Complaint seeking recovery under ERISA § 502(a)(3) for breach of fiduciary duty in light of the concurring opinion of Justices Ginsburg and Breyer in the *Aetna* case. The defendants stipulated to the filing of the new complaint and the defendants then moved to dismiss the Second Amended Complaint under Rule 12(b)(6) for failure to state a claim.

Following oral argument on October 11, 2005, District Judge Alvin K. Hellerstein granted the motions to dismiss, stating his principle reasons as follows:

> Mr. Seymour, [with] the same regret I reflected in my decision in *Gerosa v. Savasta*, I reluctantly grant the motion by the defendants to dismiss the complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure for failure to state a claim for relief.
>
> It is clear to me that the claim of Mr. Rubin-Schneiderman is for damages not equitable relief.***
>
> The allegation is that while in outpatient treatment, the plaintiff attempted suicide, and fortunately it was only an attempt, but the plaintiff claims injury and sues for damages.***
>
> Under Section 502(a)(3)B, the law provides that a civil action may be brought by participant beneficiary or fiduciary to obtain other appropriate equitable relief. The Supreme Court has held and the Second Circuit has held you cannot disguise a claim for damages by labeling it as a claim for equitable relief.***
>
> Mr. Seymour, I wish you well in your move up to the Second Circuit again, and I would like to see a change in the law and a liberalization of it but I think my hands are tied.
>
> (A–555-559)

ARGUMENT

WHY CERTIORARI SHOULD BE GRANTED

POINT I

JUSTICE JOSEPH STORY'S 1836 TREATISE ON EQUITABLE JURISPRUDENCE SHOWS THAT THE 1993 5-4 MAJORITY OPINION IN *MERTENS V. HEWITT* MISCONSTRUED THE PURPORTED UNAVAILABILITY OF COMPENSATORY DAMAGES AS AN EQUITABE REMEDY AGAINST FIDUCIARIES DURING THE TIME OF THE DIVIDED BENCH

Associate Justice Story's Commentaries on Equity Jurisprudence as Administered in England and America, first published in 1836, was a major reference and teaching tool through fourteen editions, the last appearing in 1918, more than 60 years after his death.

In Equity Jurisprudence, Story devotes an entire chapter to "Compensation and Damages" (Ch. XIX at pages 104-109). The chapter begins with the generality used as the premise for the majority opinion in *Mertens*, that monetary damages were usually left to courts of law, but then goes on to qualify that generality by an important exception that was overlooked in the majority opinion in *Mertens* – and requires the opposite outcome in the context of ERISA's Section 502(a)(3) remedies:

> It may be stated, as a general proposition, that, for breaches of contract and other wrongs and injuries, cognizable at law, Courts of Equity do not entertain jurisdiction to give redress by way of compensation or damages, where these constitute the sole object

> of the bill. For, wherever the matter of the bill is merely for damages, there the remedy is properly at law, and can be better ascertained by a Jury, than by the conscience of the Chancellor. And, indeed, the just foundation of equitable jurisdiction fails in all such cases, as there is a plain, complete, and adequate remedy at law. Compensation or damages (it should seem) ought to be decreed in Equity only as incidental to other relief asked, and usually given; or, where there is no adequate remedy at law.
>
> Story, Equity Jurisprudence, 104-5 (1st ed., 1836) (emphasis added) (citing English, Federal and State cases as authority.)[2]

There is no adequate remedy at law under ERISA, as the history of the present case so clearly demonstrates (see Procedural History, *supra*), and as this Court has now squarely so held in *Aetna v. Davila*, 542 U.S. 200 (2004).

The *Davila* denial of any adequate remedy at law for beneficiaries of employee health care plans for breach of statutory and professional fiduciary duties by administrators activates the exception to the general equity denial of damages – to wit, "...where there is no adequate remedy at law."

Justice Story explained the reason behind this exception in Section 798 of his Equity Jurisprudence, *supra*, pages 107-108), stating:

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[2] Justice Story's lengthy footnote includes the following statement:

> Though plaintiff has a remedy at law, this will not oust jurisdiction. It must be plain and adequate, and as certain, prompt, complete, and efficient to attain the ends of justice and its prompt administration as the remedy in equity. (citing four American cases) (fn.1, page 474)

> [W]here no ... remedy lies at law, there a peculiar ground for the interference of Courts of Equity exists, to prevent irreparable mischief, or to avoid a fraudulent advantage being take of the injured party.[3]

Preventing a "fraudulent advantage being taken of the injured party" is exactly what is at issue under ERISA today, as set forth in greater detail in Point III. As will be seen, the time is now here for this court to vacate the majority opinion in *Mertens* as promptly and decisively as possible.

POINT II

AETNA v. DAVILA FIRMLY CLOSED THE DOOR ON LEGAL REMEDIES FOR INJURED ERISA BENEFICIARIES, AND SIMULTANEOUSLY PROVIDED THE BASIS FOR OPENING THE DOOR TO EQUITABLE COMPENSATORY DAMAGES

On June 21, 2004, a unanimous Court handed down its decision the the consolidated cases of *Aetna Health Inc. v. Juan Davila* and *Cigna Healthcare of Texas, Inc. v. Ruby R. Calad, etal*, 542 U.S. 200 (2004). The decision marked a major milestone in ERISA health benefit litigation: (1) it established without any equivocation or room for doubt that no common law remedies are available for ERISA beneficiary claims for injuries against plan administrators; and (2) that medical necessity health care decisions by physicians employed by plan administrators are fiduciary

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[3] A lengthy footnote cites a number of English and American authorities, including a decision of this Court in *Pratt v. Law*, 9 Cranch, 493, 494.

decisions, not "treatment" decisions.

Those unanimous rulings directly contradict the very premise of the majority opinion in *Mertens* that equitable remedies under § 502(a)(3) cannot include monetary damages. They trigger Justice Story's exception, and therefore require reversal of the judgment below in this case.

No Adequate Remedy at Law

The key language in *Aetna v. Davila* prohibiting any legal remedy for beneficiary injuries under ERISA appears on pages 208 and 209 of the Court's opinion:

> ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Russell*, 473 U.S., at 147 (internal quotation marks and citation omitted). This integrated enforcement mechanism, ERISA § 502(a), 29 U.S.C. § 1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans.
>
> * * *
>
> Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.
>
> * * *
>
> Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary

> state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule."

Medical Necessity Determinations Are Fiduciary Decisions

The Court's other major ruling in *Aetna v. Davila* was that medical necessity determinations that are made as part of an Administrator's review of health benefits are fiduciary decisions and are not independent treatment decisions, as many courts and others (including this plaintiff) had mistakenly interpreted *Pegram v. Herdrich* 530 U.S. 211 (2000).

> Hence, a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. See *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) (relevant plan fiduciaries owe a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims"). The fact that a benefits determination is infused with medical judgments does not alter this result.
>
> 542 U.S. 200, at 219

Historically, Equity Has Required a Fiduciary Who Violates His Duties to "Repair All The Damages"

The earliest known standard work on equity was Henry Ballow, A Treatise on Equity, published in London in 1737. Book V of that work (starting at page 117) deals exclusively with Damages. Section 1 begins as follows:

> Since a Man is bound in Equity, not only to perform his Engagements, but also to repair all the Damages

> that accrue naturally from the Breach of them: We ought not to omit treating of these .... As for Damages in general, the measure of them is to be taken from the Quality of the Action, the Cause, and the Event. For where there is any Fraud or knavish Dealing, the Sentence ought to have the utmost Extent that the Rigor of the Law can give it; because the Knavery implies a Will and Intention to do all the Hurt that is possible.

Quaint as these words sound today, in substance they fit exactly the plaintiff's claim against the fiduciary defendants in this case.

Ballow's successor, John Fonblanque, continued this same language in A Treatise on Equity, printed in 1795. The language was also reprinted in the American editions of Ballow's work. (*E.g.*, 3rd edition, printed in Philadelphia in 1805, at pp. 419-413.)

Likewise, the American writer, John Adams, in his The Doctrine of Equity: Being a Commentary on the Law as Administered in the Court of Chancery (Philadelphia, 1850), states (at page 93): "If a breach of trust has been committed, the trustee will be liable to make good any consequent loss, whether immediately resulting from it, or traceable as its effect."

Although these are pre-ERISA cases and deal primarily with fiduciary duties in handling financial matters, the equity "make-whole" doctrine [argued by the United States as *amicus* in *Aetna v. Davila*, see 542 U.S. 200 at 221, fn.7] plainly was a form of damages widely used by courts of equity during the time of the divided bench, and should be fully available to plaintiffs seeking an appropriate equitable remedy under § 502(a)(3).

POINT III

ERISA, AS PRESENTLY INTERPRETED BY THIS COURT, ALLOWS HEALTH INSURERS TO TAKE "FRAUDULENT ADVANTAGE OF THE INJURED PARTY" (JUSTICE STORY'S WORDS)

The practical effects of ERISA, as presently interpreted by *Mertens*, are discussed in Circuit Judge Becker's concurring opinion in *DiFelice v. Doe*, 346 F.3d 442, (3rd Cir., 2003), at pp. 453 *et seq*.

> ... ERISA generally and § 514(a) particularly, have become virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided.
>
> (*Id*., at 456)

Judge Becker provides a practical, common sense description of the negative results caused by denying equitable damages under ERISA:

> The unavailability of extra-contractual damages has effects that are perverse. First, as stated above, contingency fees are rendered entirely impractical – precious few lawyers would be willing to undertake a horrendously complex case of uncertain outcome when the greatest potential reward is merely provision of the care that had been contractually promised. Without contingency fees, participants in the midst of medical crises are completely at the

mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where – as with Mr. DiFelice – the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participant's malady. To the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory.

The second perverse effect is that, at the same time as ERISA makes it inordinately difficult to bring an injunction to enforce a participant's rights, it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see Pilot Life*, 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else

> being equal, the most profitable HMOs will be those that deny claims most frequently.
>
> In sum, ERISA's remedial scheme gives HMO's every incentive to act in their own and not in their beneficiaries best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess, a confounding result for a statute whose original purpose was to protect employees.
>
> (*Id.*, at 459)

Like other judges concerned about the consequences of the *Mertens* majority opinion, Judge Becker has urged that either Congress or the Supreme Court act soon to correct the damage the decision has produced. Realistic observers of today's campaign finance abuses in Congress – and the huge sums that the health care industry has poured into Congressional incumbents' campaign coffers – are painfully aware that expecting remedial action from Congress in the foreseeable future is a pipe dream. If change is to come, it must be from the Supreme Court itself. The one sure way to speed up that change is to award compensatory damages to this plaintiff under § 502(a)(3).

Judge Becker's colleague, 3rd Circuit Judge Ambro, joined him in urging the Supreme Court to reverse and rewrite the *Mertens* decision:

> I join the chorus calling for a fresh look from higher authority to promote better the primary Congressional purpose of ERISA – protecting plan participants and their beneficiaries. (*Id.*, at 468)

In her concurring opinion in *Aetna v. Davila*, Justice Ginsburg (joined by Justice Breyer) urged resolution of the unjust and increasingly tangled judicial interpretations of ERISA by utilizing the relief available under Section 502(a)(3) in the remedial sense, by making the plaintiff whole for defendants' wrongdoing through a monetary award under traditional trust law.

This solution was explicitly proposed by the Government in its *amicus* brief filed on behalf of the Secretary of Labor in the *Aetna* case in the Supreme Court, and was endorsed by the two Associate Justices in their concurring opinion. (542 U.S. 200 at 222.)

The Supreme Court majority at the end of its opinion in *Aetna Health Care, Inc. v. Davila* also noted the potential applicability of "make whole" monetary equitable remedies to award relief, but declined to rule on the question until a proper case presented the issue squarely:

> The United States, as *amicus*, suggests that some individuals in respondents' positions could possibly receive some form of "make-whole" relief under ERISA §502(a)(3). Brief for United States as *Amicus Curiae* 27, n. 13. However, after their respective District Courts denied their motions for remand, respondents had the opportunity to amend their complaints to bring expressly a claim under ERISA §502(a). Respondents declined to do so; the District Courts therefore dismissed their complaints with prejudice. See App. 147-148; *id.*, at 298; App. B to Pet. for Cert. in No. 02-1845, pp. 34a-35a; App. B to Pet. for Cert. in No. 03-83, p. 40a. Respondents have thus chosen not to pursue any ERISA claim, including any claim arising under

> ERISA §502(a)(3). The scope of this provision, then, is not before us, and we do not address it.
>
> (542 U.S.200 at 221, fn.7.)

This action presents that issue squarely.

CONCLUSION

"Chancery is ordained to supply the Law, not to subvert the Law." – Lord Bacon[4]

The judgment below should be reversed, *Mertens* should be revisited and corrected, and plaintiff should be allowed to seek compensatory damages under ERISA § 502(a)(3).

Respectfully submitted,

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October 31, 2006

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[4] From the title page of Joseph Story's Commentaries on Equity Jurisprudence (1st ed.,1836)

APPENDIX

APPENDIX

JUDGMENT OF DISTRICT COURT	A-1
ORDER AND JUDGMENT OF COURT OF APPEALS	A-2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

ERIC RUBIN-SCHNEIDERMAN,

Plaintiff,

-against-

MERIT BEHAVIORAL CARE CORP., M.D., SATI AHULWALIA, EMPIRE BLUE CROSS AND BLUE SHIELD,

Defendants.

----------x

00 **CIVIL** 8101 (AKH)

JUDGMENT

Whereas the above-captioned action having come before this Court, and the matter having come before the Honorable Alvin K. Hellerstein, United States District Judge, and the Court, on October 12, 2005, having rendered its Order granting defendant's motion to dismiss, it is,

ORDERED, ADJUDGED AND DECREED: That for the reasons stated in the Court's Order dated October 12, 2005, defendant's motion to dismiss is granted; accordingly, the case is closed.

Dated: New York, New York
October 18, 2005

J. MICHAEL McMAHON

BY: /s/
Deputy Clerk

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

SUMMARY ORDER

THIS SUMMARY ORDER WILL NOT BE PUBLISHED IN THE FEDERAL REPORTER AND MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY TO THIS OR ANY OTHER COURT, BUT MAY BE CALLED TO THE ATTENTION OF THIS OR ANY OTHER COURT IN A SUBSEQUENT STAGE OF THIS CASE, IN A RELATED CASE, OR IN ANY CASE FOR PURPOSES OF COLLATERAL ESTOPPEL OR RES JUDICATA.

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, Foley Square, in the City of New York, on the 14th day of August, two thousand and six.

PRESENT:

HON. ROBERT D. SACK
HON. ROBERT A. KATZMAN
Circuit Judges,
HON. J. GARVAN MURTHA*
District Judge.

- -

ERIC RUBIN-SCHNEIDERMAN,
Plaintiff-Appellant, No. 05-5851

-v-

MERIT BEHAVIORAL CARE CORPORATION, EMPIRE BLUE CROSS and BLUE SHIELD,
Defendants-Appellees.

- -

*Of the United States District Court for the District of Vermont, sitting by designation.

Appearing for Appellant:	WHITNEY NORTH SEYMOUR, JR., NEW YORK, NY
Appearing for Appellees Merit Behavioral Care Corporation and Sati Ahluwalia:	JONATHAN K. COOPERMAN, Kelley, Drye & Warren (Jennifer A. Huber, of counsel, New York, NY
Appearing for Appellee Empire Blue Cross and Blue Shield:	DALY D.E. TEMCHINE, Epstein Becker & Greene, P.C., New York, NY.

Appeal from the United States District Court for the Southern District of New York (Alvin K. Hellerstein, Judge).

UPON DUE CONSIDERATION, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the judgment be, and it hereby is, AFFIRMED.

The plaintiff, Eric Rubin-Schneiderman, brought suit against the defendants – Empire Blue Cross and Blue Shield ("Empire"), his health insurance company; Merit Behavioral Care Corporation ("Merit"), the company that performs utilization review of mental health services for Empire; and Sati Ahluwalia, an employee of Merit – under section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3). He alleged that the defendants negligently failed to authorize his hospitalization in a psychiatric facility and that, as a result of this negligence, he suffered permanent injury from a failed suicide attempt. The district court granted the

defendants' motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) on the ground that, under recent Supreme Court precedents beginning with Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), the monetary damages Rubin-Schneiderman sought were unavailable under ERISA § 502(a)(3). [SPA 3-6]

Rubin-Schneiderman's primary argument on appeal is that Mertens was wrongly decided and we should not follow it. But "[w]e cannot overrule the Supreme Court." Bach v. Pataki, 408 F.3d 75, 86 (2d Cir. 2005); see also Rodriguez de Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477, 484 (1989); Cicio v. Does, 321 F.3d 83, 106-07 (2d Cir. 2003) (Calabresi, J., dissenting in part), vacated and remanded, 542 U.S. 933 (2004). Mertens and its progeny are binding on us and we are obligated to follow those decisions. See, e.g., Coan v. Kaufman, --- F.3d ----, 2006 WL 2075129, at *10, 2006 U.S. App. LEXIS 18444, at *33 (2d Cir. July 21, 2006).

Rubin-Schneideman also urges us to adopt Justice Ginsburg's suggestion in Aetna Health Inc. v. Davila, 542 U.S. 200 (2004), that monetary relief under section 502(a)(3) may be more widely available in suits against ERISA fiduciaries than against non-fiduciaries. See id. at 223-24 (Ginsburg, J., concurring). As we recently concluded, however, the fact that a defendant is a fiduciary does not change the requirement of section 502(a)(3) that the relief sought be "equitable." See Coan, 2006 WL2075129, at *11, 2006 U.S. App. LEXIS 18444, at 36-37; Sereboff v. Mid Atlantic Med. Servs., Inc., --- U.S. ---, 126 S.Ct. 1869, 1874 (2006). Because Rubin-Schneiderman is seeking compensatory monetary damages,

a legal remedy, he cannot proceed under ERISA § 502(a)(3).

For the foregoing reasons, the judgment of the District Court is hereby AFFIRMED.

FOR THE COURT:
ROSEANN B. MACKECHNIE, Clerk
/s/ Lucille Carr
By:

(2)

No. 06-614

Supreme Court, U.S.
FILED
DEC 4 - 2006
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

Petitioner,

v.

MERIT BEHAVIORAL CARE CORPORATION, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENTS MERIT BEHAVIORAL CARE CORPORATION AND DR. SATI AHLUWALIA

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COUNTER-STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Should this Court overturn holdings established in cases ranging from *Mertens* to *Sereboff*, and followed by each and every Circuit Court of Appeals, that ERISA Section 502(a)(3) does not permit the award of compensatory damages, especially when Petitioner's equitable arguments rely upon the same type of historical treatises that this Court has previously considered and rejected?

2. Should this Court continue to adhere to its view that ERISA embodies a careful statutory balancing of interests and that it is up to Congress to amend ERISA to permit the type of relief that Petitioner seeks?

3. Should Petitioner be allowed to pursue compensatory damages when Petitioner chose not to pursue his ERISA-created remedy?

4. Should Petitioner be allowed to pursue a claim against Respondent based upon a 1997 incident when the claim was discharged in bankruptcy?

STATEMENT PURSUANT TO RULE 29.6

Respondent, Merit Behavioral Care Corporation, is wholly owned by Magellan Health Services Inc., a publicly traded corporation.

TABLE OF CONTENTS

	Page
Counter-Statement of Issues Presented for Review	i
Statement Pursuant to Rule 29.6	ii
Table of Contents	iii
Table of Cited Authorities	v
Counter-Statement of the Case	1
Counter-Statement of Facts	2
Reasons for Denying the Petition	6
I. There Is No Compelling Reason To Grant Certiorari	6
A. Petitioner's Arguments Were Long Ago Considered and Rejected By This Court in *Mertens*, Which Found That Money Damages Are Not Available Under ERISA Section 502(a)(3)	7
B. The Rule of *Mertens* Has Been Specifically Followed By This Court	8
C. This Court Has Recognized That ERISA Represents A Careful Balancing of Interests By Congress and That It Is Up To Congress To Change ERISA To Allow for Compensatory Damages	12

Contents

Page

D. Every Circuit Has Followed *Mertens* and Its Progeny and Held That Money Damages Are Not Available Under ERISA Section 502(a)(3) 15

E. Petitioner Had An ERISA Remedy, But Chose Not To Pursue That Remedy ... 16

II. None Of The Sources Cited By Petitioner Provides A Compelling Reason For Overturning *Mertens* 18

III. This Is Not A Proper Case For Review For The Additional Reason That The Claim Against Respondent Merit Has Been Discharged In Bankruptcy 20

Conclusion 22

TABLE OF CITED AUTHORITIES

Page

Cases:

Aetna Health Inc. v. Davila,
542 U.S. 200, 124 S.Ct. 2488 (2004) . . 10, 11, 13, 16, 17

Broaddus v. Florida Power Corp.,
145 F.3d 1283 (11th Cir. 1998) 16

Buckley Dement, Inc.
v. Travelers Plan Adm'rs of Ill, Inc.,
39 F.3d 784 (7th Cir. 1994) 16

Callery v. U.S. Life Ins. Co. in the City of NY,
392 F.3d 401 (10th Cir. 2004) 16

Coop. Benefit Adm'rs, Inc. v. Ogden,
367 F.3d 323 (5th Cir. 2004) 16

Downes v. JP Morgan Chase & Co.,
2004 WL 1277991 (S.D.N.Y. June 8, 2004) 16

Dozsa v. Crum & Forster Ins. Co.,
716 F. Supp. 131 (D. N.J. 1989) 17

Gerosa v. Savasta & Co., Inc.,
329 F.3d 317 (2d Cir. 2003) 15-16

Great-West Life & Annuity Insurance Company
v. Knudson,
534 U.S. 204, 122 S.Ct. 708 (2002) 9, 10, 11, 19

Cited Authorities

Page

Griggs v. E.I. Dupont de Nemours & Co.,
385 F.3d 440 (4th Cir. 2004) 16

Helfrich v. PNC Bank, Kentucky, Inc.,
267 F.3d 477 (6th Cir. 2001) 16

In re Commercial Millwright Serv. Corp.,
245 B.R. 603 (Bankr. N.D. Iowa 2000) 21

In re Texaco Inc.,
182 B.R. 937 (Bankr. S.D.N.Y. 1995) 21, 22

In re Unisys Corp. Retiree Med.
Benefit "ERISA" Litig.,
57 F.3d 1255 (3d Cir. 1995) 16

Kerr v. Charles F. Vatterott & Co.,
184 F.3d 938 (8th Cir. 1999) 16

Marro v. K-III Commc'ns Corp.,
943 F. Supp. 247 (E.D.N.Y. 1996) 17

Massachusetts Mutual Life Insurance Company
v. Russell, 473 U.S. 134, 105 S.Ct. 3085 (1985) ... 8

Mattive v. Healthsource of Savannah, Inc.,
893 F. Supp. 1559 (S.D.Ga. 1995) 17

Mertens v. Hewitt Associates,
508 U.S. 248, 113 S.Ct. 2063 (1993) .....*passim*

Cited Authorities

Page

Montgomery County Maryland v. Metromedia Fiber Network, Inc., 326 B.R. 483 (S.D.N.Y. 2005) 21

Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549 (1987) 12, 14

Reich v. Rowe, 20 F.3d 25 (1st Cir. 1994) 15

Reynolds Metals Co. v. Ellis, 202 F.3d 1246 (9th Cir. 2000) 16

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 122 S.Ct. 2151 (2002) 10, 13

Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. __, 126 S.Ct. 1869 (2006) .....i, 2, 11, 12

Varity Corporation v. Howe, 516 U.S. 489, 116 S.Ct. 1065 (1996) 9, 14, 16

Statutes:

11 U.S.C. § 101(12) 22

11 U.S.C. § 1141(d)(1)(A) 21

29 U.S.C. § 1132(a)(3) .....*passim*

29 U.S.C. § 1132(a)(1)(B) 6, 16, 17

29 U.S.C. § 1132(g)(1) 6, 17

Cited Authorities

Page

Rules:

U.S. Supreme Court Rule 10(a) 6, 7, 15

U.S. Supreme Court Rule 10(b) 7

U.S. Supreme Court Rule 10(c) 7

COUNTER-STATEMENT OF THE CASE

Respondents Merit Behavioral Care Corporation ("Merit") and Dr. Sati Ahluwalia respectfully request that this Court deny the petition for writ of certiorari seeking review of the Second Circuit's opinion in this case. There are no compelling reasons for the Court to grant this petition.

Based largely upon dated treatises, Petitioner urges this Court to overturn a large body of case law holding that compensatory damages are not available for an alleged breach of ERISA Section 502(a)(3) (29 U.S.C. Section 1132(a)(3)). This Court has long recognized that ERISA reflects a careful Congressional balancing of interests. As part of this balancing, Congress chose not to permit individuals such as Petitioner to obtain compensatory damages. Congress instead created a remedy whereby individuals such as Petitioner, upon denial of his requested benefits, could have sued to recover those benefits, and, if successful, recover his attorneys fees. Petitioner chose not to pursue that ERISA remedy, but instead brought this lawsuit three years later to recover compensatory damages. Petitioner urges this Court to overturn *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063 (1993), which held that Section 502(a)(3) does not permit a plaintiff to recover the type of compensatory damages that Petitioner seeks. It is noteworthy that in the thirteen years since this Court decided *Mertens*, Congress has not amended ERISA to change the careful balancing of interests repeatedly observed by this Court.

This Court has on a number of occasions after *Mertens* held that the type of compensatory damages sought by the Petitioner are not available under ERISA Section 502(a)(3). Indeed, earlier this year this Court reaffirmed this position

on the scope of equitable relief available under Section 502(a)(3) in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. __, 126 S.Ct. 1869, 1873-74 (2006). No conflict on this issue exists between or among the Courts of Appeals, or between any lower court and this Court. Each and every Court of Appeals has rejected Petitioner's argument for an expansion of ERISA § 502(a)(3) to include compensatory damages. Finally, none of the dated sources cited by Petitioner provide compelling reasons for granting review. This Court has specifically considered and rejected such arguments based on similar sources on several occasions. The decisions of the lower courts in this case were fully consistent with the established precedent. The petition should therefore be denied.

COUNTER-STATEMENT OF FACTS

Petitioner's father, David Schneiderman, and his mother, Anita Rubin, are both employed at Barson Hardware Co. ("Barson Hardware"). (A. 63).[1] As part of their employment, Barson Hardware provided group health coverage through the Barson Hardware Plan to both David Schneiderman and Anita Rubin, as well as their eligible dependent children, including Petitioner, "through a contract purchased from Defendant Empire." (A. 63).

The Barson Hardware Empire Plan provides a covered person with the option to obtain in-network or out-of-network benefits. (A. 68-69). A covered person such as the Petitioner may choose his or her own treating physicians. (A. 69). A utilization manager then decides whether the treatment

1. References to "A. __" are to the Record on Appeal before the Second Circuit.

suggested by the covered person's own treating physician is covered under the Barson Hardware Plan. (A. 84-86). If a plan member chooses in-network coverage, Article II, titled "Utilization Management Program," provides a number of steps for the member to follow in order to determine if the requested treatment is covered under the member's plan. (A. 84-86). If the requested benefit is covered under the Barson Hardware Plan, the insured may obtain reimbursement for that treatment. *Id.*

Under the Barson Hardware Plan, the utilization review manager and its agents are not the treating physicians. Nor do they provide any medical treatment whatsoever to the covered person. *Id.* Instead, the role of utilization review managers is solely to make determinations regarding benefit coverage under the Barson Hardware Plan. (A. 85).

Respondent Merit is a corporation that provides utilization review management for Empire for the mental health care portion of the Barson Hardware Plan. (A. 85). Merit is alleged to have provided utilization review in order "to determine whether mental health services proposed to be rendered to [Empire] beneficiaries were medically necessary and therefore covered under the BlueChoice PPO program." (A. 11-12, ¶¶ 3, 9).

Respondent Dr. Ahluwalia was a physician employed by Merit who performed utilization review services on Merit's behalf. (A. 11, ¶ 4). She was not Petitioner's treating physician. Nor was she involved in examining or evaluating Petitioner in person. (A. 14, ¶ 16).

Petitioner had been under psychiatric care, (A. 12-13, ¶ 10), and his treating psychiatrist was Dr. Samuel C.

Klagsbrun, a doctor not employed by or affiliated with Merit or Empire. In August 1997, Petitioner's treating physician recommended in-patient psychiatric care at Four Winds Hospital. (A. 13, ¶ 11). In an effort to obtain coverage for in-patient care, Petitioner's father, David Schneiderman, contacted an unidentified person at Merit's Mental & Nervous Disorders In-patient Division regarding Petitioner's request for pre-approval for in-patient treatment at Four Winds Hospital. (A. 165, ¶ 9). The Merit employee contacted by David Schneiderman stated that Petitioner was required to undergo a pre-admission assessment at Four Winds before Merit could determine whether benefits would be authorized. *Id.*

On September 8, 1997, Petitioner underwent a preauthorized psychiatric evaluation at Four Winds and applied to Merit for preauthorization of his admission. (A. 13, ¶ 13). This preauthorization process is alleged to have consisted of telephone conversations between the Four Winds evaluating physician and unidentified Merit employees. *Id.* Petitioner alleges that unidentified Merit medical personnel then orally denied coverage for Petitioner's admission to Four Winds Hospital. (A. 13, ¶ 14).

Respondent Dr. Ahluwalia is alleged only to have written a letter the following day, September 9, 1997, confirming Merit's prior oral determination that Petitioner did not meet the recognized national professional criteria to be eligible to receive benefits for in-patient care at Four Winds. (A. 13-14, ¶ 15). Dr. Ahluwalia wrote as follows:

> Based on the information that we received and national professional criteria for medical necessity, MBC cannot authorize inpatient

> psychiatric treatment at Four Winds Hospital effective 09/08/97. It can not be authorized for the following reasons:
>
> Based on information given, current level of symptoms can be treated at a lower level of care. Recommendation is for an intensive outpatient program.
>
> Regardless of our determination you and the patient have the ultimate responsibility for determining the appropriateness of treatment.

(A. 178).

Dr. Ahluwalia provided no medical or treatment-related information in her September 9, 1997 letter, beyond informing Petitioner that he was eligible to receive benefits for treatment at an out-patient, rather than in-patient, facility. Dr. Ahluwalia did not opine on the appropriateness of any particular type of medical treatment for Petitioner's condition.

Petitioner's treating physician (who is not a defendant in this action) agreed with the statement in Dr. Ahluwalia's letter that Petitioner could be treated as an out-patient. (A. 179). Indeed, in a subsequent letter to Merit and Dr. Ahluwalia, Petitioner's own physician described an out-patient program as "absolutely appropriate for Eric," albeit at a different facility than Four Winds. *Id.*

Upon Merit's denial of the requested benefits coverage for in-patient care, Petitioner had the right to commence an immediate action under ERISA seeking an injunction to:

> Recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B) (ERISA § 502(a)(1)(B)). Additionally, ERISA provides that a Court has the discretion to award attorneys fees and costs of the action to the plaintiff where there was an improper denial of benefits. ERISA § 502(g)(1).

However, Petitioner chose not to avail himself of the remedies to which he was entitled under ERISA and, instead, elected to accept coverage for out-patient benefits. Seven months after the benefits denial for in-patient care, Petitioner is alleged to have attempted to commit suicide. (A. 14-15, ¶ 20). Petitioner commenced this action more than three years after the September 9, 1997 letter reiterating Merit's prior oral denial of benefits for in-patient care.

REASONS FOR DENYING THE PETITION

I. THERE IS NO COMPELLING REASON TO GRANT CERTIORARI

Rule 10 of the Rules of the Supreme Court of the United States outlines common considerations governing review on certiorari and provides that "[a] petition for a writ of certiorari will be granted only for compelling reasons." This petition falls within none of the categories which, while "neither

controlling nor fully measuring the Court's discretion, indicate the character of the reasons the Court considers." There is no conflict among decisions of United States Courts of Appeals, or between United States Courts of Appeals and state courts of last resort (Rule 10(a) & (b)). The lower court's decision does not represent a substantial departure "from the accepted and usual course of judicial proceedings" by a United States Court of Appeals, justifying an exercise of the Supreme Court's supervisory power (Rule 10(a)). To the contrary, the lower courts carefully followed the established precedent of this Court. This is also not a situation where a decision by a state court or a United States Court of Appeals of an important question of federal law either has not yet been settled by this Court or conflicts with the relevant decisions of this Court (Rule 10(c)).

Petitioner essentially asks this court to overturn a body of caselaw decided by this Court and followed by each of the eleven Circuit Courts of Appeal. Certiorari should be denied.

A. Petitioner's Arguments Were Long Ago Considered and Rejected By This Court in *Mertens*, Which Found That Money Damages Are Not Available Under ERISA Section 502(a)(3)

In *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063 (1993), this Court firmly held that § 502(a)(3) does not permit an award of monetary damages. The *Mertens* Court determined that the "equitable relief" contemplated by Section 502(a)(3) is limited to "those categories of relief that were *typically* available in equity," including injunction, mandamus, and restitution, "but not compensatory damages." *Id.* at 256, 113 S.Ct. at 2069 (emphasis in original). The

Mertens Court explicitly rejected the argument, based on "ERISA's roots in the common law of trust," that the same remedies available in a suit for enforcement of a trust were intended to be available in an ERISA action. *Id.* at 255, 113 S.Ct. at 2068. This Court noted that the enforcement of a trust by the courts of equity was merely an example of "'*legal* remedies' granted by an *equity* court," *Id.* at 256, 113 S.Ct. at 2069 (emphasis added), and thus not "equitable relief" within the meaning of Section 502(a)(3). This Court explained:

> Since *all* relief available for breach of trust could be obtained from a court of equity, limiting the sort of relief obtainable under § 502(a)(3) to "equitable relief" in the sense of "whatever relief a common-law court of equity could provide in such a case" would limit the relief *not at all*. We will not read the statute to render the modifier superfluous.

Id. at 257-58, 113 S.Ct. at 2069 (emphasis in original). Similarly, in *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134, 145-46, 105 S.Ct. 3085, 3092 (1985), this Court noted that Congress had included "legal or equitable relief" in an early draft version of ERISA, but specifically dropped the reference to "legal" relief in the final statute.

B. The Rule of *Mertens* Has Been Specifically Followed By This Court

The petition reads as if the 1993 *Mertens* case was a once-decided case otherwise at odds with a body of law and commentary. In fact, the legal principle set forth in *Mertens*,

that compensatory damages are not "equitable relief" under ERISA, has been cited and followed in a number of subsequent decisions by this Court. In *Varity Corporation v. Howe*, 516 U.S. 489, 509-10, 116 S.Ct. 1065, 1076 (1996), this Court cited *Mertens* for the proposition that "compensatory and punitive damages are not 'equitable relief' within the meaning of [ERISA § 502(a)(3)]" in discussing an individual's right to bring an ERISA claim.

More recently, in *Great-West Life & Annuity Insurance Company v. Knudson*, 534 U.S. 204, 122 S.Ct. 708 (2002), this Court revisited the definition of "equitable relief" in Section 502(a)(3). In *Great-West*, petitioners attempted to characterize the relief they sought as "equitable" within the *Mertens* standard, requesting specific performance of a reimbursement provision of ERISA, and restitution of the proceeds from the respondents' tort action. This Court stated that "an injunction to compel the payment of money past due under a contract, or specific performance of a past due monetary obligation, was not typically available in equity," and thus dismissed petitioners' claim for specific performance. *Great-West*, 534 U.S. at 210-11, 122 S.Ct. at 713.

The *Great-West* Court also rejected petitioners' assertion that the restitution they were seeking was a form of equitable relief, holding:

> [N]ot all relief falling under the rubric of restitution is available in equity. In the days of the divided bench, restitution was available in certain cases at law, and in certain others in equity. . . . In cases in which the plaintiff "could *not* assert title or right to possession of particular

> property, but in which nevertheless he might be able to show just grounds for recovering money to pay for some benefit the defendant had received from him," the plaintiff had a right to restitution *at law*. . . . In contrast, a plaintiff could seek restitution *in equity* . . . where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession.

Id. at 212-13, 122 S.Ct. at 714 (*quoting* 1 Dobbs § 4.2(1) at 571) (other citations omitted) (emphasis in original). Thus, although restitution could occasionally be characterized as "equitable," the restitution sought in *Great-West* – "the imposition of personal liability for the benefits that they conferred upon respondents" – was legal in nature. *Id.* at 214, 122 S.Ct. at 715. Thus, this Court held that "§ 502(a)(3) does not authorize this action." *Id.* at 221, 122 S.Ct. at 719. Here, by contrast, there is no need to make fine distinctions between equitable and legal restitution, as Petitioner admittedly seeks compensatory damages, which the *Great-West* and *Mertens* Courts termed "the classic form of *legal* relief." *Id.* at 210, 122 S.Ct. at 713 (emphasis in original).

In *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S.Ct. 2488 (2004), this Court also stated that monetary relief is not available under § 502(a)(3), discussing the prior holding in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151 (2002) as follows:

> There, we described our holding in *Ingersoll-Rand* as follows: "[W]hile state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under

> § 1132(a)(3) . . . into a legal one for money damages . . ." 536 U.S., at 379, 122 S.Ct. 2151. The point of this sentence was to describe why the state cause of action in *Ingersoll-Rand* was pre-empted by ERISA § 502(a): It was pre-empted because it attempted to convert an equitable remedy into a legal remedy.

542 U.S. at 215-16, 124 S.Ct. at 2499.

Earlier this year, this Court yet again affirmed its position that damages are not available under ERISA § 502(a)(3). In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. __, 126 S.Ct. 1869 (2006), this Court stated as follows:

> In *Mertens v. Hewitt Associates*, 508 U. S. 248 (1993), we construed [ERISA § 502(a)(3)] to authorize only "those categories of relief that were *typically* available in equity," and thus rejected a claim that we found sought "nothing other than compensatory *damages*."

Sereboff, 547 U.S. at __, 126 S.Ct. at 1873 (emphasis in original). This Court distinguished Mid Atlantic's situation, in which monetary relief was available, from the situation in *Great-West Life & Annuity Insurance Company v. Knudson*, where monetary relief was not available, by noting:

> Unlike Great-West, Mid Atlantic did not simply seek "to impose personal liability . . . for a contractual obligation to pay money." *Knudson*, 534 U. S. at 210, 122 S.Ct. 708. It alleged breach of contract and sought money, to be sure, but it sought its recovery through a constructive trust

> or equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law.

Sereboff, 547 U.S. at __, 126 S.Ct. at 1874.

Like Great-West, Petitioner seeks to impose liability for a contractual obligation to pay money. He does not seek its recovery through a constructive trust or equitable lien on a specifically identified fund, but seeks it through Respondents' collective assets generally. This is not equitable relief as this Court has defined that term in *Mertens* and the cases that followed.

C. This Court Has Recognized That ERISA Represents A Careful Balancing of Interests By Congress and That It Is Up To Congress To Change ERISA To Allow for Compensatory Damages

This Court has time and again firmly rejected attempts to expand ERISA-remedies from those specifically enumerated by Congress. As stated in *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 54, 107 S.Ct. 1549, 1556 (1987),

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain

> remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."

(emphasis in original) (citation omitted); *see also Davila*, 542 U.S. at 208-09, 124 S.Ct. at 2495.

This Court has recognized that Congress viewed an important public interest of ERISA as encouraging employers to offer benefit plans and was concerned that employers might be discouraged to do so if they were subject to costly litigation seeking compensatory damages. *See Rush Prudential HMO, Inc.*, 536 U.S. at 379, 122 S.Ct. at 2166 (discussing "ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities"); *Mertens*, 508 U.S. at 262-63, 113 S.Ct. at 2072 (noting the tension between ERISA's goals of benefiting employees and containing pension costs). In enacting ERISA remedies, Congress chose the public interest of fuller insurance coverage over granting individual plan participants the right to obtain compensatory damages. As stated in *Davila*, 542 U.S. at 215, 124 S.Ct. at 2499, "[t]he limited remedies available under ERISA are an inherent part of the 'careful balancing' between ensuring fair and prompt

enforcement of rights under a plan and the encouragement of the creation of such plans."

Similarly, in *Varity Corporation*, 516 U.S. at 497, 116 S.Ct. at 1070, this Court recognized that the enumerated ERISA enforcement procedures are part of "Congress' desire to offer employees enhanced benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, *or litigation expenses*, unduly discourage employers from offering welfare benefit plans in the first place" (emphasis added). The *Mertens* Court recognized that ERISA was "the product of a decade of congressional study of the Nation's private employee benefit system" (508 U.S. at 251, 113 S.Ct. at 2066) and that Courts should not adjust the balance struck by Congress of the competing goals of "benefiting employees and the subsidiary goal of containing pension costs" (*Id.* at 262-63, 113 S.Ct. at 2072). As stated by the *Pilot Life* Court,

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

Pilot Life Ins. Co., 481 U.S. at 54, 107 S.Ct. at 1556.

Accordingly, while Petitioner asserts that obtaining compensatory damages is an important interest, this Court has recognized that Congress in creating ERISA carefully balanced several other competing public interests.

D. Every Circuit Has Followed *Mertens* and Its Progeny and Held That Money Damages Are Not Available Under ERISA Section 502(a)(3)

According to Supreme Court Rule 10(a), one factor that this Court will consider when determining whether to grant review is whether:

> a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power.

Rule 10(a). This factor is not present here; there is no allegation of a departure from the "accepted and usual course of judicial proceedings," and the Second Circuit's decision in this case does not conflict with the decision of another United States Court of Appeals or state court of last resort.

In fact, there is no circuit split; every circuit has recognized *Mertens* as controlling and has held that money damages are not available under ERISA Section 502(a)(3). *See Reich v. Rowe*, 20 F.3d 25 (1st Cir. 1994); *Gerosa v.*

Savasta & Co., Inc., 329 F.3d 317 (2d Cir. 2003); *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 57 F.3d 1255 (3d Cir. 1995); *Griggs v. E.I. Dupont de Nemours & Co.*, 385 F.3d 440 (4th Cir. 2004); *Coop. Benefit Adm'rs, Inc. v. Ogden*, 367 F.3d 323 (5th Cir. 2004); *Helfrich v. PNC Bank, Kentucky, Inc.*, 267 F.3d 477 (6th Cir. 2001); *Buckley Dement, Inc. v. Travelers Plan Adm'rs of Ill, Inc.*, 39 F.3d 784 (7th Cir. 1994); *Kerr v. Charles F. Vatterott & Co.*, 184 F.3d 938 (8th Cir. 1999); *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 2000); *Callery v. U.S. Life Ins. Co. in the City of NY*, 392 F.3d 401 (10th Cir. 2004); *Broaddus v. Florida Power Corp.*, 145 F.3d 1283 (11th Cir. 1998).

E. Petitioner Had An ERISA Remedy, But Chose Not To Pursue That Remedy

Justice Ginsburg's *Davila* concurrence cited by Petitioner expressed concern for those situations in which a plaintiff "affected by ERISA-proscribed wrongdoing" cannot gain "make-whole relief." *Davila*, 542 U.S. at 222, 124 S.Ct. at 2503. Petitioner does not have the type of situation addressed by Justice Ginsburg. *Cf. Varity Corp.*, 516 U.S. at 515, 116 S.Ct. at 1079 ("They must rely on the *third* subsection [§502(a)(3)] or they have no remedy at all") (emphasis in original).

Indeed, upon being denied coverage for in-patient care in 1997, Petitioner could have commenced an immediate action under ERISA § 502(a)(1)(B) seeking an injunction to obtain the very same in-patient care. *Cf. Downes v. JP Morgan Chase & Co.*, 2004 WL 1277991, *2 (S.D.N.Y. June 8, 2004) ("it is questionable . . . whether an action pursuant to § 502(a)(3) can seek '*appropriate* equitable relief' where, as here, another ERISA provision (here, § 502(a)(1)(B))

offers the plaintiff adequate relief") (emphasis in original); *Davila*, 542 U.S. at 210, 124 S.Ct. at 2496 ("if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B) . . . then the individual's cause of action is completely preempted . . .").

ERISA § 502(a)(1)(B) provides for a civil action by a plan participant or beneficiary,

> to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, as to clarify his rights to future benefits and on the terms of the plan.

29 U.S.C. § 1132(a)(1)(B). This section has been repeatedly used by plan participants to successfully obtain plan benefits. *See, e.g., Marro v. K-III Commc'ns Corp.*, 943 F.Supp. 247 (E.D.N.Y. 1996); *Dozsa v. Crum & Forster Ins. Co.*, 716 F.Supp. 131 (D. N.J. 1989); *Mattive v. Healthsource of Savannah, Inc.*, 893 F.Supp. 1559 (S.D.Ga. 1995). If Petitioner had pursued this statutory remedy, he could have even been awarded his attorneys' fees and costs if successful. ERISA § 502(g)(1).

Here, Petitioner did not pursue his ERISA rights. He instead waited over three years to bring this action seeking compensatory damages. Petitioner should not be able to use ERISA § 502(a)(3) to obtain money damages in the guise of equitable relief when he long ago made a conscious and voluntary choice to abstain from utilizing ERISA § 502(a)(1)(B) to obtain the treatment he now claims that he needed.

II. NONE OF THE SOURCES CITED BY PETITIONER PROVIDES A COMPELLING REASON FOR OVERTURNING *MERTENS*

The sources cited by Petitioner provide no compelling reasons for overturning *Mertens*. Petitioner cites treatises from the years 1737, 1795, 1836, and 1850 in an attempt to force compensatory monetary damages under the rubric of "equitable relief" as that term is used in the ERISA statute enacted in 1974. In fact, this Court has specifically considered Petitioner's argument concerning the trust law analogy and the availability of damages in courts of equity at the time of the divided bench, and has nevertheless found that damages are not within the scope of "appropriate equitable relief" under ERISA § 502(a)(3).

Justice White's dissent in *Mertens* discusses the availability of "a compensatory monetary award . . . in the equity courts under the common law of trusts." *Mertens*, 508 U.S. at 263, 113 S.Ct. at 2072. Like Petitioner, the dissent similarly quoted from historical treatises and cases. *Id.* at 266, 113 S.Ct. at 2074 (quoting J. Tiffany & E. Bullard, *Law of Trusts and Trustees*, 585-86 (1862)); *Id.* at 270, 113 S.Ct. at 2076 (citing *Stevens v. Gladding*, 17 How. 447 (1855); *Livingston v. Woodworth*, 15 How. 546 (1854); 2 J. Sutherland, *Law of Damages* § 392 (3d ed. 1903); W. Hale, *Law of Damages*, 319 (2d ed. 1912); 1 T. Sedgwick, *Measure of Damages* § 371 (8th ed. 1891)). The majority of the Court recognized the existence of such authority but ultimately determined that "appropriate equitable relief" under ERISA § 502(a)(3) did not include everything that could be awarded at the time of the divided bench. *Mertens*, 508 U.S. at 256-58, 113 S.Ct. at 2068-70.

In *Great-West*, this Court specifically addressed the viability of the law-equity dichotomy and its effect in the context of ERISA § 502(a)(3):

> It is easy to disparage the law-equity dichotomy as "an ancient classification" . . . and an "obsolete distinction[n]" . . . Like it or not, however, that classification and distinction has been specified by the statute; and there is no way to give the specification meaning—indeed, there is no way to render the unmistakable limitation of the statute a limitation *at all*—except by adverting to the differences between law and equity to which the statute refers.

Great-West, 534 U.S. at 216-17, 122 S.Ct. at 716 (internal citations omitted) (emphasis in original). This Court also noted the current "well known" contours of the term "equitable relief," and further stated, "[r]arely will there be need for any more 'antiquarian inquiry.'" *Id.* at 217, 122 S.Ct. at 716. Finally, this Court noted the confusion in "congressional use (and lawyers' understanding) of the statutory term 'equity'" if that term was revised to include legal remedies, even if such remedies were available in courts of equity at the time of the divided bench. *Id.* at 217, 122 S.Ct. at 716-17.

Thus, rather than offering any reason as to why a well-settled body of case law should be overturned, Petitioner offers the same type of historical arguments that this Court has already considered and rejected.

III. THIS IS NOT A PROPER CASE FOR REVIEW FOR THE ADDITIONAL REASON THAT THE CLAIM AGAINST RESPONDENT MERIT HAS BEEN DISCHARGED IN BANKRUPTCY

On March 11, 2003, Respondent Merit and certain of its affiliated entities filed voluntary petitions for relief under chapter 11 of title 11 of the United States Code in the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court"), Case No. 03-40515 (PCB) (Jointly Administered). On June 3, 2003, Petitioner, as an alleged creditor of Merit, filed with the Bankruptcy Court a proof of claim against Merit (Claim Number 444) seeking recovery for the same claims that Petitioner alleged in this action (the "Bankruptcy Claim").

On October 8, 2003, the Bankruptcy Court entered an Order granting the Debtors' First Omnibus Objection to Proofs of Claim (the "Objection Order"). (A. 347-50). Listed under Exhibit "E," captioned "Litigation Claims – To Be Expunged" is this very claim against Merit (A. 385) in which the Court "ORDERED that each of the claims identified in Exhibits 'B' through 'F' hereto is hereby disallowed and expunged in its entirety" (A. 348). Also on October 8, 2003, the Bankruptcy Court entered an Order confirming the Debtors' Third Amended Joint Plan of Reorganization, dated August 18, 2003 (the "Confirmation Order"). (A. 446-512).

Pursuant to the Confirmation Order, the Bankruptcy Court discharged and enjoined the assertion of all claims

> based upon any act or omission, transaction, or other activity of any kind or nature that occurred prior to the Effective Date [as defined in the

> confirmed plan], whether or not such holder has filed a proof of claim or proof of equity interest, and whether or not the facts of, or legal bases, therefore, were known or existed prior to the Effective Date.

(A. 496). The Effective Date occurred on January 5, 2004. *See Montgomery County Maryland v. Metromedia Fiber Network, Inc.*, 326 B.R. 483, 496-97 (S.D.N.Y. 2005) (once a claim is expunged, the alleged obligation is entirely unenforceable).

Upon confirmation of a reorganization plan, the company that filed for bankruptcy ceases to exist. The newly reorganized company, while perhaps having the same name, is a new and separate legal entity and the discharge operates as a bar to proceeding with claims against the discharged entity. *See, e.g., In re Commercial Millwright Serv. Corp.*, 245 B.R. 603, 606 (Bankr. N.D. Iowa 2000) ("[t]he reorganized debtor operates as a new entity, free of its preconfirmation obligations except as provided in the plan").

In *In re Texaco Inc.*, 182 B.R. 937, 949 (Bankr. S.D.N.Y. 1995), the Court stated that Section 524(a)(2) of the Bankruptcy Code "expressly provides that the discharge operates as a permanent injunction against the commencement or continuation of any action to recover discharge[d] claims." *Id.* "[Section 524(a)] is intended to insure that once a debt is discharged, the debtor will not be pressured in any way to repay it. In effect the discharge extinguishes the debt, and creditors may not attempt to avoid that." *Id.* (quoting H.R. Rep. 595, 95th Cong., 1st Session 365-66 (1977); S. Rep. No. 989, 95th Cong., 2nd Session 80 (1978)). Pursuant to 11 U.S.C. § 1141(d)(1)(A), the

confirmation of a plan discharges the debtor from any debt that arose before the date of such confirmation, and the word "debt" is defined by 11 U.S.C. § 101(12) as "liability on a *claim*." *In re Texaco Inc.*, 182 B.R. at 950 (emphasis in original).

Neither the District Court nor the Second Circuit below considered this issue in dismissing Petitioner's Complaint. Nevertheless, this is a threshold reason why this case is not appropriate for certiorari.

CONCLUSION

For these reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

Petitioner,

v.

MERIT BEHAVIORAL CARE CORPORATION, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT EMPIRE BLUE CROSS AND BLUE SHIELD

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QUESTION PRESENTED FOR REVIEW

Whether this Court should grant certiorari in a case in which the only issue of law presented, whether damages may be awarded as relief under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3), has been resolved by long settled ERISA precedent, and as to which there are no conflicts between any courts.

CORPORATE DISCLOSURE STATEMENT

Empire HealthChoice Assurance, Inc., doing business as Empire Blue Cross and Blue Shield, is wholly owned by WellPoint, Inc. through WellPoint Holding Corp. and WellChoice Holdings of New York, Inc. WellPoint, Inc. is a publicly traded company and no publicly held company owns ten percent or more of its stock. Neither Empire HealthChoice Assurance, Inc., WellPoint Holding Corp. nor WellChoice Holdings of New York, Inc. are publicly traded.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED FOR REVIEW	i
CORPORATE DISCLOSURE STATEMENT	ii
TABLE OF CONTENTS	iii
TABLE OF CITED AUTHORITIES	v
INTRODUCTION	1
STATEMENT OF THE CASE	2
Statement of Facts	2
Procedural History	3
SUMMARY OF ARGUMENT	6
REASONS FOR DENYING THE PETITION	7
I. PRINCIPLES OF *STARE DECISIS* REQUIRE THAT CERTIORARI BE DENIED IN THIS CASE	7
II. SETTLED ERISA LAW PRECLUDES THE RELIEF PETITIONER SEEKS	8
A. Petitioner's Claims Are Actionable Solely Under Section 502(a)(1)(B) of ERISA	8

Contents

Page

B. Petitioner's Contention That ERISA's Remedial Scheme Enables Insurers to Take "Fraudulent Advantage" of Plan Participants Is a Baseless "Red Herring" Intended to Create the Appearance of an Issue That Is the Subject of Judicial Controversy 15

C. Clear Precedent Holds That Availability of Relief Under Section 502(a)(1)(B) Precludes *Any* Type of Relief Under Section 502(a)(3) 17

D. That Damages Are Not Available Under Section 502(a)(3) of ERISA Is Confirmed by All Applicable Precedent And Petitioner's Contention to the Contrary Does Not Raise a New or Controversial Issue 21

E. This Court Has Already Determined That Congress Expressly Rejected Damages as an Available Remedy Under Section 502(a)(3). 26

CONCLUSION 29

TABLE OF CITED AUTHORITIES

Page

FEDERAL CASES

Abbruscato v. Empire Blue Cross & Blue Shield, 274 F.3d 90 (2d Cir. 2001) 18

Aetna Health Inc. v. Davila/Cigna Healthcare of Texas, Inc. v. Calad, 542 U.S. 200 (2004) ..... *passim*

Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53 (4th Cir. 1996) 10

Barnhart v. Peabody Coal Co., 537 U.S. 149 (2003) 27

Estate of Bratton v. National Union Fire Insurance Co. of Pittsburgh, 215 F.3d 516 (5th Cir. 2000) ... 18

Braxton v. United States, 500 U.S. 344 (1991) 1

Carson v. American Brands, Inc., 450 U.S. 79 (1981) 1

Cicio v. Does, 321 F.3d 83 (2d Cir. 2003) 4

Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76 (2d Cir. 2001) 18

DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442 (3d Cir. 2003) 15

Donovan v. Mazzola, 716 F.2d 1226 (9th Cir. 1983) 25

Cited Authorities

Page

Dozsa v. Crum & Forster Insurance Co., 716 F. Supp. 131 (D.N.J. 1989) 13

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 25

Flowers v. United States, 764 F.2d 759 (11th Cir. 1985) 7

Forsyth v. Humana, Inc., 114 F.3d 1467 (9th Cir. 1997) 18

Frommert v. Conkright, 433 F.3d 254 (2d Cir. 2006) 18, 23

Gerosa v. Savasta & Co., 329 F.3d 317 (2d Cir. 2003) 20, 22, 23

Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (2002) 7, 20, 21, 22

Hall v. UNUM Life Insurance Co. of America, 300 F.3d 1197 (10th Cir. 2002) 10

Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc., 530 U.S. 238 (2000) 25

Henderson v. Bodine Aluminum, Inc., 70 F.3d 958 (8th Cir. 1995) 10

Hughes Aircraft Co. v. Jacobson, 525 U.S. 432 (1999) 25

Cited Authorities

Page

Johnson v. Buckley, 356 F.3d 1067 (9th Cir. 2004) ... 18

Katz v. Comprehensive Plan of Group Insurance, ALLTEL, 197 F.3d 1084 (11th Cir. 1999) 19

Knieriem v. Group Health Plan, Inc., 434 F.3d 1058 (8th Cir. 2006) 23

Larocca v. Borden, Inc., 276 F.3d 22 (1st Cir. 2002) 18

Lee v. Burkhart, 991 F.2d 1004 (2d Cir. 1993) 22

Marro v. K-III Communications Corp., 943 F. Supp. 247 (E.D.N.Y. 1996) 13

Mass. Mutual Life Insurance Co. v. Russell, 473 U.S. 134 (1985) 16, 26

Mattive v. Healthsource of Savannah, Inc., 893 F. Supp. 1559 (S.D. Ga. 1995) 13

Mertens v. Hewitt Associates, 508 U.S. 248 (1993) ..... *passim*

Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58 (1987) 20

Neal v. United States, 516 U.S. 284 (1996) 8

Nechis v. Oxford Health Plans, Inc., 421 F.3d 96 (2d Cir. 2005) 18, 23

Cited Authorities

Page

Ogden v. Blue Bell Creameries U.S.A., Inc., 348 F.3d 1284 (11th Cir. 2003) 19

Patterson v. McLean Credit Union, 491 U.S. 164 (1989) 7, 8

Payne v. Tennessee, 501 U.S. 808 (1991) 8

Peralta v. Hispanic Bus., Inc., 419 F.3d 1064 (9th Cir. 2005) 23

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) 20

Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266 (3d Cir. 2001) 10, 13

Ragsdale v. Wolverine World Wide, Inc., 535 U.S. 81 (2002) 28

Rhorer v. Raytheon Eng'rs & Constructors, Inc., 181 F.3d 634 (5th Cir. 1999) 18

Seales v. Amoco Corp., 82 F. Supp. 2d 1312 (M.D. Ala. 2000) 19

Sinai Hospital of Baltimore v. National Benefit Fund for Hospital & Health Care Employees, 697 F.2d 562 (4th Cir. 1982) 25

Tolson v. Avondale Industrial, 141 F.3d 604 (5th Cir. 1998) 18

Page

Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196 (1st Cir. 1997) 18

United States v. Vonn, 535 U.S. 55 (2002) 27

Ute Indian Tribe v. Utah, 935 F. Supp. 1473 (D. Utah 1996) 7

Varity Corp. v. Howe, 516 U.S. 489 (1996) .. 9, 17, 18, 20

Wald v. Sw. Bell Corp. Customcare Medical Plan, 83 F.3d 1002 (8th Cir. 1996) 19

Welch v. Tex. Department of Highways and Public Transport, 483 U.S. 468 (1987) 7

White v. Caterpillar, Inc., 765 F. Supp. 1418 (W.D. Mo) 14

Wilson v. Group Hospital & Medical Services, Inc., 791 F. Supp. 309 (D.D.C. 1992) 14

STATUTES

ERISA § 2(a), 29 U.S.C. § 1001(a) (2000) 12

ERISA § 2(b), 29 U.S.C. § 1001(b) (2000) 12

ERISA § 404, 29 U.S.C. § 1104 (2000) 5

ERISA § 502, 29 U.S.C. § 1132 (2000) 5, 18

Page

ERISA § 502(a)(1)(A), 29 U.S.C. §§ 1132(a)(1)(A) (2000) 4

ERISA § 502(a)(1)(B), 29 U.S.C. §§ 1132(a)(1)(B) (2000) ..... *passim*

ERISA § 502(a)(2), 29 U.S.C. §§ 1132(a)(2) (2000) 4, 16

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (2000) ..... *passim*

ERISA § 502(g), 29 U.S.C. § 1132(g) (2000) 10

ERISA § 504, 29 U.S.C. § 1134 (2000) 5

ERISA § 505, 29 U.S.C. § 1135 (2000) 5

OTHER AUTHORITY

H.R. Rep. No. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639 ..... 25, 27

S. Rep. No. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838 27

Davila/Calad, On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit, Brief for the United States as Amicus Curiae Supporting Petitioners, 2003 WL 23011479 (Dec. 18, 2003) 14

Cited Authorities

Page

James F. Jorden, et al., *Handbook on ERISA Litigation*, § 4.04[1][c] n.130 (2d ed. 1996) 19

Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West, 103 Colum. L. Rev. 1317, 1327 (2003) 24-25

INTRODUCTION

The case presented by Petitioner fails to satisfy any of the criteria for granting certiorari established by this Court in its Rules and in applicable precedent. Rule 10 of the Rules of the Supreme Court of the United States provides that "a petition for a writ of certiorari will be granted *only for compelling reasons*" (emphasis added). Rule 10 further defines the circumstances in which a Writ of Certiorari may be issued as follows: a) a federal court's decision has created a conflict with other federal circuits' rulings on the issue presented, or between a federal and a state court on a question of federal law; b) a state court of last resort has created a conflict with other such state courts or with federal courts on a federal question; or c) a federal appeals court has decided an issue that has not been addressed by this Court or in a way that conflicts with prior decisions of this Court. *See also Braxton v. United States*, 500 U.S. 344, 347 (1991) ("A principal purpose for which we use our certiorari jurisdiction . . . is to resolve conflicts among the United States courts of appeals and state courts concerning the meaning of provisions of federal law."); *Carson v. Am. Brands, Inc.*, 450 U.S. 79, 82-83 (1981).

This case satisfies none of these criteria. The issue presented for review is whether a damages remedy is provided by ERISA to plan participants for a wrongful benefit denial by a plan fiduciary. Petitioner candidly concedes, as he must, that the ruling of the court below, that ERISA does *not* provide a damages remedy, is squarely grounded on Supreme Court precedent, and is wholly in accord with the rulings of all other federal courts on this issue. He seeks to have this Court abandon and reverse its consistent prior precedents in order to create a damages remedy under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). The sole basis for his argument is that the Court has for decades repeatedly failed to comprehend the true scope of the remedies available in courts of equity that were not adopted from courts of law.

The core fact of this case is that the Petitioner failed to avail himself of the remedy provided by ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), that was specifically crafted by Congress to provide relief to plan participants who believe that they were wrongly denied a claim for benefits. Thus, even if the Petition here satisfied the requirements of Rule 10, and it does not, the threshold question for the Court to resolve would be whether ERISA's remedies set out in Section 502(a) should be amended and a new one created for participants who elect to ignore the statute's existing remedy for improper benefit denials. This threshold question is not a justiciable controversy, as it presents a legislative issue that only Congress has the authority to address and resolve.

STATEMENT OF THE CASE

Statement of Facts

Petitioner Eric Rubin-Schneiderman was covered under a group health policy purchased by an ERISA Health and Welfare Plan (the "Plan") (A-67 – A-131).[1] Empire was the Plan Administrator, and was required in that capacity to determine whether particular health care services for which coverage was sought by Plan members satisfied, among other considerations, the utilization review and management ("UM/UR") standards specified by the Plan's governing documents. Empire had the authority to subcontract the performance of certain of these functions, and contracted with Merit to perform the UM/UR function for the mental health benefits covered by the Plan.

In August 1997, one of Petitioner's treating physicians opined that his mental health condition should be treated in an inpatient psychiatric facility. (A-165, ¶ 8.) Approval for coverage of the proposed admission was requested from Merit. Merit denied the request, through its employee Dr. Ahluwalia, on the ground that inpatient treatment was not a covered Plan benefit

[1] Citations to the record refer to the Joint Appendix filed with the Second Circuit below on January 18, 2006.

in the circumstances presented. (A-178.) Contrary to Petitioner's characterization of this coverage decision, Dr. Ahluwalia and Merit did not "overrule" his treating physician, nor did Dr. Ahluwalia "misdiagnose" Petitioner. (Pet.'s Br. 3, 4.) Dr. Ahluwalia was not Petitioner's treating physician and did not purport to give him medical advice or treatment. She neither could, nor did she, prohibit or bar Petitioner from obtaining the treatment recommended by his treating physician. She only applied the coverage guidelines of Petitioner's ERISA plan and determined that, under the UM/UR guidelines, inpatient treatment was not a covered benefit.

A letter explaining Merit's denial of inpatient treatment was sent to the Petitioner that also informed him of his rights of review and appeal. (A-178.) Neither he, nor anyone on his behalf, pursued the available coverage denial appeal procedures, and no attempt to obtain judicial review of the denial was made. (A- 296.)

Approximately seven months after the denial of coverage, Petitioner apparently attempted to commit suicide. During that seven month period, he was receiving outpatient treatment that was covered by Empire. At no time during those seven months was the request for coverage for inpatient treatment renewed, and no information regarding a worsening of the Petitioner's condition was provided to either Empire or Merit. Petitioner first sought recourse for the benefit denial by later filing a lawsuit for damages.

Procedural History

Petitioner commenced this action on September 29, 2000, some three years after the benefit coverage denial. He filed a state court action asserting various negligence claims against defendants Merit, Ahluwalia, and Empire. Defendants removed the case to the United States District Court for the Southern District of New York and filed separate motions to dismiss the state law claims. Both the removal and the motions to dismiss were predicated on ERISA preemption grounds. Petitioner filed

a motion to remand the case to state court which was denied, and the motions to dismiss were granted on April 9, 2001.

Petitioner then filed an Amended Complaint in the District Court on April 26, 2001, restating his state law claims and asserting ERISA claims under sections 502(a)(1)(A), 502(a)(1)(B) and 502(a)(2), 29 U.S.C. §§ 1132(a)(1)(A), (a)(1)(B), and (a)(2). The relief demanded included damages and attorneys' fees. Defendants again filed motions to dismiss, and they were granted on November 14, 2001. The District Court again ruled that the state law claims were preempted by ERISA, and also ruled that the ERISA causes of action did not state a claim for which the relief demanded by Petitioner could be granted.

An appeal was taken by Petitioner to the United States Court of Appeals for the Second Circuit which, on April 18, 2003, remanded the case for consideration in light of the then-recent decision in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *cert. granted, vacated by Vytra Healthcare v. Cicio*, 542 U.S. 933 (2004), *remanded to Cicio v. Does*, 385 F.3d 156 (2d Cir. 2004). On remand, Defendants once again moved to dismiss and, on August 27, 2003, the District Court confirmed its earlier ruling and dismissed Petitioner's Amended Complaint a second time.

Petitioner filed a second appeal to the Second Circuit. After the opening briefs were filed, that Court granted Defendants' previously filed motion to stay and amended the schedule to permit further briefing and argument following the decision then pending before this Court in *Aetna Health Inc. v. Davila/Cigna Healthcare of Texas, Inc. v. Calad*, 542 U.S. 200 (2004). The latter decision was issued on June 21, 2004. Petitioner acknowledged that the *Davila/Calad* decision repudiated his contention that he could assert state law negligence claims seeking damages on the basis of a benefit coverage denial decision. He filed a Supplemental Brief on August 27, 2004, requesting that the Second Circuit remand the matter to the District Court so that he might file a new proposed Second

Amended Complaint asserting a claim for damages under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (2000). On January 31, 2005 the Second Circuit affirmed the District Court's dismissal of the First Amended Complaint, but remanded the case to allow Petitioner to again amend his complaint to assert a Section 502(a)(3) claim seeking damages as relief for the denial of coverage for the inpatient treatment.

A Second Amended Complaint was filed on May 31, 2005, asserting a claim under 502(a)(3), as well as two new counts purporting to be based on ERISA Section 404, 29 U.S.C. § 1104 (2000).[2] Defendants' subsequent motions to dismiss that complaint were granted, and the dismissal was affirmed by the Second Circuit on August 15, 2006. Petitioner has thus had his ERISA claims dismissed three times.[3]

Petitioner contends that this case is part of a "long judicial search for an ERISA remedy to permit beneficiaries to seek compensatory damages." (Pet.'s Br. 2-3). That no such search exists, or has ever existed, is confirmed by controlling, longstanding precedents. These precedents repeatedly affirm that ERISA's remedial structure accurately reflects the clearly expressed congressional determination that damages are not a permissible remedy under ERISA. Indeed, as detailed below, even when the Secretary of Labor, who is charged with the administration and enforcement of ERISA,[4] and the Solicitor General have argued to the Court that a damages remedy for plan participants and their beneficiaries should be inferred from the text of Section 502(a), this Court has rejected their arguments.

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[2] Section 404 does not provide any causes of action or forms of relief under ERISA.

[3] Thus contrary to Petitioner's assertion on page 3 of his brief, this is his fourth appeal.

[4] *See, e.g.*, ERISA §§ 502, 504, 505, 29 U.S.C. §§ 1132, 1134, 1135.

There are only a very few expressions, appearing in dissents and concurring opinions, that a damages remedy should, somehow, be conjured from the statute's unsupportive text. These isolated expressions appear against a backdrop of consistent and uniform rulings that Congress did not intend to allow for a damages remedy under ERISA. The Second Circuit's opinion below is but one more such unexceptional ruling.

SUMMARY OF ARGUMENT

The issue presented by the Petitioner has been litigated time and again, and its resolution is well settled by controlling precedent from this Court that has been consistently applied by the Circuit Courts, including the court below. There is no controversy among either the lower federal courts or the highest state courts regarding the meaning and effect of this Court's decisions governing the issue raised by Petitioner. That issue is whether the courts should engraft a new remedy onto Section 502 of ERISA that allows relief in the form of compensatory and other damages, notwithstanding Congress' express decision not to provide for such relief in ERISA.

Petitioner's claim that the lack of a damages remedy leaves him and others like him without effective relief when plan benefits are wrongly denied to them is specious. This Court has consistently held that Section 502(a)(1)(B) of ERISA provides the exclusive remedy for exactly such situations. Here, it was the Petitioner's election not to avail himself of that remedy that is the sole cause of his demand that all prior direct precedent be repudiated, and that a damages remedy be found to exist in ERISA.

Petitioner's contention that this Court, in its prior decisions confirming the unavailability of a damages remedy under ERISA, failed to understand the scope of equitable remedies available under the common law is without basis, and ignores a fundamental element of ERISA. That element is that Congress did not haphazardly incorporate into Section 502(a) of ERISA any and all equitable remedies available at common law, but

deliberately crafted a specific set of statutory remedies that were to be the exclusive remedies available to ERISA plan participants. There is no need to revisit established precedent that has properly given effect to congressional intent.

For these reasons, the Petition for a Writ of Certiorari should be denied.

REASONS FOR DENYING THE PETITION

I. PRINCIPLES OF *STARE DECISIS* REQUIRE THAT CERTIORARI BE DENIED IN THIS CASE

In decision after decision, this Court, as have lower federal courts, has adhered to the principle that ERISA does not afford compensatory damages under section 502(a)(3) of ERISA. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). The law is well settled in this area, and Petitioner offers no good reason why this Court should now conclude that it has for decades grievously misunderstood the intent of Congress and, thus, misconstrued the scope of ERISA's remedial provisions in case after case. Petitioner's attempt to convince this Court to revisit and reverse its consistent prior decisions also is barred by the bedrock principles of *stare decisis* that this Court follows.

Stare decisis is one of the central principles of American jurisprudence. *Welch v. Tex. Dep't of Highways and Pub. Transp.*, 483 U.S. 468, 494 (1987). The doctrine literally means "to abide by the precedents and not to disturb settled points." *Ute Indian Tribe v. Utah*, 935 F. Supp. 1473, 1509 n.55 (D. Utah 1996). While this Court *may* depart from its prior holdings when necessary and appropriate, *stare decisis* prevents cases from being decided in an arbitrary fashion, and reflects the salutary principle that like cases should be treated alike. *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989); *Flowers v. United States*, 764 F.2d 759, 761 (11th Cir. 1985). This Court has emphasized that "[*s*]*tare decisis* is the preferred course because it promotes the evenhanded, predictable, and consistent

development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Payne v. Tennessee*, 501 U.S. 808, 827 (1991).

Deference to prior decisions is considered to be especially important in the area of statutory interpretation. *Neal v. United States*, 516 U.S. 284 (1996); *Patterson*, 491 U.S. at 172 (*stare decisis* has "special force in the area of statutory interpretation" because "the legislative power is implicated, and Congress remains free to alter what we have done"). This case squarely involves an issue of statutory interpretation and, absent truly compelling reasons, entirely absent here, this Court's prior decisions interpreting ERISA's remedial provisions should not be disturbed. Congress has never taken any actions that reasonably suggest that the Court's decisions are based on a misinterpretation of the intent of Congress with respect to the remedies available under Section 502(a).

II. SETTLED ERISA LAW PRECLUDES THE RELIEF PETITIONER SEEKS

A. Petitioner's Claims Are Actionable Solely Under Section 502(a)(1)(B) of ERISA

Plaintiff's core contention is that ERISA leaves plan participants and beneficiaries with no recourse when their plans are improperly administered and wrongful denials of benefits occur. He seeks to advance his contention by focusing on only one prong of ERISA's carefully crafted and comprehensive remedial scheme, Section 502(a)(3), while completely failing to acknowledge the existence of Section 502(a)(1)(B). This omission is deliberate, as the existence of Section 502(a)(1)(B) completely undermines Petitioner's argument.

In order to effectuate Congress' goal of protecting the interests of employee benefit plan members in obtaining the benefits their plans promise to them, Section 502(a)(1)(B) of ERISA empowers plan members to bring civil actions to obtain

those benefits when they have been improperly denied.[5] On its face, the text of Section 502(a)(1)(B) wholly contradicts Petitioner's core contention that ERISA does not provide a remedy for plan members who are wrongfully denied covered benefits, as it unambiguously provides express remedies for improper benefit coverage denials. In addition, Section 502(a)(1)(B) is the *exclusive* remedy for plan participants' claims based on benefit denials. *See Davila/Calad*, 542 U.S. at 210 ("[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted by ERISA § 502(a)(1)(B)."). [6] This case involves only an allegedly improper benefit denial.

Any claim grounded upon an allegedly improper denial of a benefit due may only be brought under Section 502(a)(1)(B), and not under any other provision of ERISA. *See Varity Corp. v. Howe*, 516 U.S. 489 (1996) (equitable relief under Section 502(a)(3) is only available if no other remedy is available under ERISA; availability of recourse under Section 502(a)(1)(B) precludes seeking relief under Section 502(a)(3)). In this case, a single act is asserted to be the cause of all of Petitioner's injuries and is the basis of the damages he seeks to obtain; that act is the allegedly wrongful denial of coverage for inpatient treatment. Established precedent from this Court and lower courts compels the conclusion that *all* of Petitioner's entitlements to judicial relief therefore arise under Section 502(a)(1)(B) alone.

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[5] 29 U.S.C. § 1132(a)(1)(B) (2000) ("A civil action may be brought by a participant or beneficiary to *recover benefits* due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.") (emphasis added).

[6] Indeed, Petitioner asserted a Section 502(a)(1)(B) claim in his First Amended Complaint. It was dismissed because the relief he sought was not a benefit, but compensatory and punitive damages.

Petitioner not only seeks to have the Court repudiate its rulings that Section 502(a)(1)(B) provides the exclusive remedy for improper benefit denials, he also seeks to have the Court discard its well-established definition of what constitutes "equitable relief" under ERISA. Petitioner's stated rationale for asking this Court to reverse its definition of the scope of "equitable relief" permitted to plan participants under ERISA in order to allow damages to be classified as an equitable remedy is that he cannot be "made whole" under Section 502(a)(3) as currently construed.

The only reason Petitioner cannot now be made whole through ERISA's exclusive remedies, assuming for the sake of argument that he has been injured because the denial of inpatient treatment was improper, is that he failed to timely utilize his Section 502(a)(1)(B) remedy, and now has no need for coverage of the inpatient treatment that was denied. The relief provided by Section 502(a)(1)(B) had its optimal value at the time his treating physician believed that inpatient treatment was necessary. If Petitioner had sought relief under that provision at that time, and a court had determined that the denial of coverage for inpatient care was improper, he would have obtained a complete remedy including, potentially, an award of attorney's fees and costs pursuant to Section 502(g). 29 U.S.C. § 1132(g). *See, e.g., Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197 (10th Cir. 2002) (affirming award of attorney's fees to plaintiff in action for denial of benefits); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001) (discussed below); *Bailey v. Blue Cross & Blue Shield of Va.*, 67 F.3d 53 (4th Cir. 1996) (granting preliminary injunction for coverage of treatment sought); *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958 (8th Cir. 1995) (same).[7]

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[7] There are dozens of similar cases that have been decided by the federal courts; a more comprehensive listing of such cases can be found in the Addendum to Respondent's brief in opposition to Petitioner's appeal to the Second Circuit, filed February 17, 2006.

Alternatively, Petitioner could have preserved the full value of the Section 502(a)(1)(B) remedy even if he did not immediately file a lawsuit. All he had to do was follow his treating physician's advice and get the inpatient care. He could thereafter have brought an action under Section 502(a)(1)(B) against Empire and Merit. If the court determined that the denial of coverage was unjustified, he would recover both the costs of the care and his attorneys' fees and litigation costs. In sum, the Section 502(a)(1)(B) remedy, if timely sought or preserved, would have provided Petitioner with all of the relief he required and was entitled to receive. The sole reason the beneficial purpose of the Section 502(a)(1)(B) remedy could not be attained in this case is that Petitioner waited some three years after the coverage denial to seek judicial relief, and also elected not to go forward with the treatment his physician recommended.

The remedy provided by Congress to plan participants for wrongful denials is neither insufficient nor flawed in any manner when it is timely and properly pursued, either: a) at the time coverage for the medical services is denied; or b) after those services have been obtained. These options provide flexibility for the pursuit of this remedy. It is true that if a plan participant obtains the services that have been denied he becomes liable for their payment. The participant thus is exposed to the risk that there will be no reimbursement of that liability if a court subsequently determines that the plan fiduciary's denial was proper. There is no sensible reason to construe that result as either an injury to the participant, or as a wrongful act by the plan's claim fiduciary. The participant has received a service which the treating physician believed would be beneficial, and thus has received value for the obligation to pay for that service. The plan fiduciary, a court has determined, acted in the manner required by the plan documents which define and limit its discretion with respect to the coverage of benefits. There is no injury and there is no wrongful act.

No provision in ERISA expresses an intent by Congress to allow plan participants the choice of foregoing the timely

exercise of their Section 502(a)(1)(B) remedy in order to subsequently pursue a damages remedy for injuries resulting from the consequences of their failure to obtain the treatment recommended by their treating physician. The purpose of health care benefit plans is to enable plan participants to obtain covered benefits when their health status requires access to those benefits. This is the public good these plans strive to achieve, as evidenced by the text of ERISA. *See generally* ERISA § 2(a) (29 U.S.C. § 1001(a)) (noting the vital importance of employee pension and welfare benefit plans and the need to protect participants' expectancy interests) and § 2(b) (29 U.S.C. § 1001(b))

> "It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.".

In Section 502(a)(1)(B), Congress specifically created a remedy that would determine entitlement to coverage of benefits *expeditiously and when it mattered.* This remedy is consistent with the intent of Congress to assure the timely delivery of promised plan benefits to participants. Congress did not intend to have ERISA health benefit plans exposed to potentially enormous financial liabilities to participants and their lawyers because of *participants'* failures to timely pursue their remedies.

This Court very clearly described the options of plan participants who believe they have been wrongly denied a health benefit in *Davila/Calad.* "[R]espondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction." *Davila/Calad*, 542 U.S.

at 211. Other federal courts have similarly recognized that these are the only options available to ERISA plan members:

> Had Pryzbowski sought to accelerate U.S. Healthcare's approval of the use of out-of-network providers, she could have sought an injunction under § 502(a) to enforce the benefits to which she was entitled under the plan, thereby using the provisions of the civil enforcement scheme provided by Congress. There have been numerous cases in which the courts have issued preliminary injunctions under similar circumstances. *See, e.g., Marro v. K-III Communications Corp.*, 943 F. Supp. 247 (E.D.N.Y. 1996) (granting preliminary injunction to compel plan administrator to precertify high dosage chemotherapy); *Mattive v. Healthsource of Savannah, Inc.*, 893 F. Supp. 1559 (S.D. Ga. 1995) (granting preliminary injunction enjoining plan administrator from denying coverage for high-dose chemotherapy); *Dozsa v. Crum & Forster Ins. Co.*, 716 F. Supp. 131 (D.N.J. 1989) (granting preliminary injunction enjoining plan administrator from denying coverage for autologous bone marrow transplant treatment).

Pryzbowski, 245 F.3d at 273-274 . *See also* discussion and citations, *supra* pp. 10-11.

In the Solicitor General's amicus brief in *Davila/Calad*, the Government clearly stated the position that ERISA Section 502(a)(1)(B) provides an effective remedy for wrongful benefit denials:

> The balance Congress struck provides effective remedies for most claimants who *promptly and properly* seek them. First, under Section 502(a)(1)(B), Congress has allowed claimants to sue not just for benefits that are due, but also to enforce their rights under the plan and clarify rights to future benefits. Thus, a claimant may bring an action under Section

> 502(a)(1)(B) to challenge a pre-treatment denial of coverage by asking a court to order a managed care company (or other entity that administers a health plan) to pay for proposed treatment. *Successful claimants may be awarded attorneys' fees. District courts have been able to act quickly to provide relief to such claimants when necessary. See, e.g., Wilson v. Group Hosp. & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992) (April 13, 1992 temporary restraining order prevented insurer from refusing to pay for April 14, 1992 treatment), *appeal dismissed*, 995 F.2d 306 (D.C. Cir. 1993); *White v. Caterpillar, Inc.*, 765 F. Supp. 1418 (W.D. Mo.) (action brought June 13, 1991; preliminary injunction issued June 26, 1991), *aff'd*, 985 F.2d 564 (8th Cir. 1991).

Davila/Calad, On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit, Brief for the United States as Amicus Curiae Supporting Petitioners, 2003 WL 23011479, at *26-27 (Dec. 18, 2003) (emphasis added) (citations omitted). Here, Petitioner asks this Court to: a) create a new remedy in ERISA for the benefit of plan participants who sit on their rights, fail to obtain the care that is the subject of a denial of coverage, and fail to pursue the specific and exclusive remedy created by Congress to deal with wrongful denials of covered benefits; and b) design that remedy so that the relief provided unambiguously constitutes damages, notwithstanding this Court's consistent rulings that only equitable remedies are available under ERISA. None of these demands presents an issue that is not disposed of by controlling precedent, or which is the subject of controversy in the courts.

B. Petitioner's Contention That ERISA's Remedial Scheme Enables Insurers to Take "Fraudulent Advantage" of Plan Participants Is a Baseless "Red Herring" Intended to Create the Appearance of an Issue That Is the Subject of Judicial Controversy.

In an unavailing effort to undermine the primacy of the Section 502(a)(1)(B) remedy with respect to claims of improper benefit denials, Petitioner looks to the dicta of Judge Becker in his *concurring* opinion in *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003), to the effect that ERISA's remedial scheme will create a "race to the bottom" by creating incentives for health plans to deny claims. There are two flaws in Petitioner's attempt to gain support from Judge Becker's statement. First, contrary to that dicta, the very purpose and intent of Section 502(a)(1)(B) is to timely prevent the potential adverse health effects of improper denials of covered health care services. It does so by providing for *immediate judicial relief* in the instance of a disputed denial of coverage. This remedy is beneficial from a health care perspective, as it operates to provide the contested health care benefits expeditiously if the denial is ruled to have been improper. Second, as previously demonstrated, the remedies which Petitioner says are supported by the referenced dicta require the failure by a participant to exercise available rights to challenge a denial of benefits and the deliberate failure to timely obtain the health care benefits in issue. It is that failure which is the cause of the adverse consequences to their health for which plan participants seek to recover damages. In effect, Petitioner is asking this Court to create a remedy that offers the prospect of a substantial economic rewards in exchange for elective conduct by plan participants that imperils their health.

The preceding result is absurd and is contrary to the clear intent of Congress to protect ERISA plans. Many of ERISA's remedies inure to the plans themselves and not to individual beneficiaries, thus reflecting congressional intent that the preservation of ERISA plans was a primary goal of the statute.

See, e.g., ERISA Section 502(a)(2) (allows suit against a plan fiduciary for breaches of fiduciary duty to the plan); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985) (ERISA's drafters "were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary."). Contrary to Petitioner's assertion that this Court in *Mertens* misconstrued basic equity law and gave insurers carte blanche to take "fraudulent advantage" of plan participants, the *Mertens* opinion reflects a realistic acknowledgment by the Court that it must balance Congress' dual goals of protecting both plan participants and the ERISA plans themselves.

If the Court were to grant Petitioner's demand for a damages remedy, ERISA plans, their fiduciaries, administrators and employer sponsors would be exposed to risks of large damage awards, and suffer the adverse effects of such risks and awards on the funding of plan benefits and costs of plan administration. Employers would find it more difficult to afford the costs of sponsoring ERISA benefit plans, and would either cease doing so or try to transfer more of those costs to plan participants. Insurers who provide fiduciary liability insurance would be compelled to increase their premiums to be commensurate with the expanded liability. Third Party Administrators and UM/UR managers, such as Merit in this case, also would be compelled to increase their charges to meet the additional costs and liability generated by the greatly expanded risk of substantial judgments. No one would benefit from the remedies Petitioner urges this Court to create other than plan participants who fail to exercise their Section 502(a)(1)(B) remedy and fail to obtain the care urged by their treating physicians and, of course, their counsel.

Because the purpose of ERISA is to ensure that beneficiaries would obtain the benefits promised to them, Congress deliberately and carefully crafted remedies that are "front-loaded." They are designed to ensure that plan participants can receive promised benefits *at the time they are most needed.* The provision for an award of attorneys' fees and costs provides

participants the means and the incentive for them to pursue that remedy expeditiously.[8] Congress could have created a "back end" remedy for plan participants, providing for damage awards after injuries have resulted from a failure to receive health services that should have been covered. In order for that remedial scheme to work, plan participants must elect not to receive the health care services at issue in order to suffer health consequences that will reap for them and their counsel a substantial financial award. Those consequences also would cause many more medical services to be required by the participants and paid for by their plans. Congress, wisely, did not create a remedy that would lead to such absurd and damaging consequences.

C. Clear Precedent Holds That Availability of Relief Under Section 502(a)(1)(B) Precludes *Any* Type of Relief Under Section 502(a)(3)

Consistent with the principle that Section 502(a)(1)(B) is the exclusive remedy for benefit denials, all directly applicable precedent uniformly holds that equitable relief under Section 502(a)(3) is *not* available to plan participants when their claims are predicated on a denial of benefits. This is the clear holding of this Court in *Varity*. There, the Court defined Section 502(a)(3) as a "catchall" provision "offering appropriate equitable relief for injuries caused by violations *that § 502 does not elsewhere adequately remedy*." *Varity*, 516 U.S. at 512 (emphasis added). This Court held that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" *Id.* at 515. The Court expressly ruled that the remedies available under Section 502(a)(1)(B) constituted just such a place where "Congress elsewhere provided adequate relief" for a claim seeking Section 502(a)(3) relief. *Id.*

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[8] *See* discussion, *supra* pp. 10-11.

The Second Circuit, in this case and in others,[9] as well as all other Circuit Courts which have ruled on the issue, have followed, as they must, the Court's clear ruling in *Varity* that, where Section 502(a)(1)(B) provides a specific remedy, relief may not be sought under Section 502(a)(3).[10] The force of this

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[9] *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96 (2d Cir. 2005); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001); *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90 (2d Cir. 2001).

[10] *See Johnson v. Buckley*, 356 F.3d 1067, 1077 (9th Cir. 2004) ("when relief is available under section 1132(a)(1), courts will not allow relief under 1132(a)(3)'s 'catch-all provision.'"); *Larocca v. Borden, Inc.*, 276 F.3d 22, 28 (1st Cir. 2002) ("federal courts have uniformly concluded that, if a Petitioner can pursue benefits under the plan pursuant to Section [502]a(1), there is an adequate remedy under the plan which bars a further remedy under Section [502](a)(3)"); *Estate of Bratton v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 215 F.3d 516, 526 (5th Cir. 2000) ("plaintiff in this purported § 502(a)(3) action is seeking only disability benefits allegedly due under the NUFI policy for which § 502 (a)(1)(B) affords an adequate remedy"); *Rhorer v. Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 639 (5th Cir. 1999) ("[I]t is readily apparent from Rhorer's complaint that her claim to recover plan benefits is the predominate [sic] cause of action in this suit. Accordingly, because § 1132(a)(1)(B) affords Rhorer an avenue for legal redress, she may not simultaneously maintain her claim for breach of fiduciary duty."); *Tolson v. Avondale Indus.*, 141 F.3d 604 (5th Cir. 1998) (holding that because Petitioner had adequate relief available for the alleged improper denial of benefits through his right to sue directly under 502(a)(1)(B), relief through the application of 502(a)(3) was inappropriate); *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997) (explaining that the Supreme Court in *Varity* "interpreted the statute to allow individual relief for a breach of fiduciary duty in an ERISA action only where no other adequate relief is available" and holding that "equitable relief under Section 1132(a)(3) is not 'appropriate' because Section 1132(a)(1) provides an adequate remedy in this case."); *Turner v. Fallon Cmty Health Plan, Inc.*, 127 F.3d 196, 200 (1st Cir. 1997)

> "Beneficiaries may sue a plan for breach of fiduciary duty causing individual harm, but . . . only for equitable relief and, even then, only where Congress has failed to provide more specific relief. Neither condition is met here since

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rule is such that it is enforced by the courts even when it is clear that a participant's claim under Section 502(a)(1)(B) would be, or has already been, unsuccessful, as in this case.[11] *See Ogden v. Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284, 1287-88 (11th Cir. 2003) (Petitioner's claims were for recovery of benefits and, therefore, could not be brought under Section 502(a)(3) even though a Section 502(a)(1)(B) claim was barred by res judicata); *Katz v. Comprehensive Plan of Group Ins., ALLTEL*, 197 F.3d 1084, 1089 (11th Cir. 1999) (even an unrealized prospect of relief under Section 502(a)(1) makes relief under Section 502(a)(3) unavailable).

Petitioner repeatedly attempts to avoid casting his claim as one for a denial of plan benefits. His efforts are a transparent attempt at "artful pleading" designed to evade the clear remedial constraints of ERISA Section 502(a)(1)(B).[12] That his claim is

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> [Petitioner] seeks damages, not equitable relief, and *his grievance – a denial of benefits – is specifically addressed by 29 U.S.C. 1132(a)(1)(B)*."

(Emphasis added) (citation omitted); *Wald v. Sw. Bell Corp. Customcare Med. Plan*, 83 F.3d 1002, 1006 (8th Cir. 1996) (holding that petitioner asserting claim under 502(a)(1)(B) cannot also seek 502(a)(3) equitable relief); *Seales v. Amoco Corp.*, 82 F. Supp. 2d 1312, 1324-5 (M.D. Ala. 2000) ("equitable relief is not warranted for the § 502(a)(3) claim for breach of fiduciary duty because the Petitioners have an adequate remedy in the 502(a)(1)(B) claim for benefits. . . . [This is so] in spite of the fact that the finding leaves the Petitioners without a remedy for the breach."). *See also* James F. Jorden, et al., *Handbook on ERISA Litigation*, §4.04[1][c] n.130 (2d ed. 1996) ("No claim for breach of fiduciary duty is available when 502(a)(1)(B) affords a remedy").

[11] When Petitioner filed his Second Amended Complaint, the Second Circuit had affirmed the dismissal of the Section 502(a)(1)(B) claim asserted in his First Amended Complaint.

[12] Plaintiffs cannot evade the exclusive character of ERISA's remedial provisions by disguising ERISA benefit denial claims as fiduciary breach

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for a benefit that was denied is plain because, if his demand for inpatient treatment had been granted, this case would not exist, as Petitioner would not have had any claim to assert. A further logical proof that Petitioner's claim is solely predicated on a denial of a benefit is that, if a court were to rule that in his circumstances inpatient treatment was not a covered plan benefit, all of Petitioner's claims would be disposed of adversely to him.

The Petitioners in *Davila/Calad* also argued that they had never asserted a claim for denial of benefits. 542 U.S. at 206. In that decision, this Court could not have been more clear in affirming the principle that, if a claim is grounded on a benefit denial, regardless of how a plaintiff labels the claim, Section 502(a)(1)(B) provides the only remedy:

> [I]f an individual, *at some point in time, could have* brought his claim under ERISA 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is *completely preempted by ERISA § 502(a)(1)(B).*

Id. at 210 (internal citations omitted) (emphasis added). Petitioner's claim can *only* be pleaded under Section 502(a)(1)(B) because it rests solely on a benefit denial. *See also Varity*, 516 U.S. 489; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Although it is clear that Petitioner's sole remedy is that provided by Section 502(a)(1)(B), he nonetheless asserts a claim for damages under Section 502(a)(3). That claim would be untenable even if, as a hypothetical matter, Section 502(a)(1)(B) were not his exclusive and sole available remedy.

(Cont'd)
claims warranting equitable relief. *See Great-West Life*, 534 U.S. at 210 (plan participant cannot bring claim for monetary relief under 502(a)(3) by labeling it "equitable" in nature); *Gerosa v. Savasta & Co.*, 329 F.3d 317, 321 (2d Cir. 2003) ("In determining the propriety of a remedy, we must look to the real nature of the relief sought, not its label").

D. That Damages Are Not Available Under Section 502(a)(3) of ERISA Is Confirmed by All Applicable Precedent And Petitioner's Contention to the Contrary Does Not Raise a New or Controversial Issue.

If, hypothetically, a Section 502(a)(3) claim could be asserted by Petitioner, the relief he seeks pursuant to that provision is unattainable. Compensatory and other forms of damages are not available under Section 502(a)(3). That provision allows beneficiaries to seek *equitable* relief for fiduciary violations of both Title I of ERISA and of a plan's governing documents. It is settled law that such equitable relief does *not* include monetary damages.

This Court clearly defined the types of equitable relief available under Section 502(a)(3) in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), and plainly held that "appropriate equitable relief" is limited to relief that was:

> typically available in equity (such as injunctions, mandamus, and restitution, *but not compensatory damages*). . . . [L]imiting the sort of relief obtainable under § 502(a)(3) to 'equitable relief' in the sense of 'whatever relief a common-law court of equity could provide in such a case' would limit the relief *not at all*. We will not read the statute to render the modifier [i.e. "equitable"] superfluous.

Id. at 256-7 (emphasis in original). This Court thus ruled that damages are not an available remedy under ERISA Section 502(a)(3).

The *Mertens* holding was followed and refined nearly ten years later in *Great-West Life and Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002).

> "[I]n *Mertens* we rejected a reading of the statute that would extend the relief obtainable under § 502(a)(3) to whatever relief a court of equity is empowered to

> provide in the particular case at issue (which could include legal remedies that would otherwise be beyond the scope of the equity court's authority)."

Id. at 210.[13] *See also Gerosa v. Savasta & Co.*, 329 F.3d 317 (2d Cir. 2003). The Court thus made it clear in *Great-West* that the equitable relief available under ERISA *does not include forms of relief that the equity courts had adopted from the law courts* such as damages.

As should be expected, the lower federal courts have consistently followed this clear line of precedent. For example, in *Gerosa,* the Second Circuit held that "classic compensatory and punitive damages are never included within 'other appropriate equitable relief.'" 329 F.3d at 321 (citing *Great-West*, *Mertens*, and *Lee v. Burkhart*, 991 F.2d 1004, 1011 (2d Cir. 1993)). The *Gerosa* Court also accurately noted this Court's instruction that the courts are not free to create additional ERISA remedies:

> Twice in its most recent term, the Court has repeated its belief that ERISA's express remedies, as the product of long and careful study and compromise, should remain exclusive. We see little room in this framework for judicially-created, 'interstitial' remedies. . . . [W]e are no longer free to fill in unwritten gaps in ERISA's civil remedies. . . . [T]he Supreme Court has instructed

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[13] The Secretary of Labor urged the Court in *Mertens* to adopt an expansive interpretation of the relief available under Section 502(a)(3)that would allow for damages. *Id.* The Court rejected that attempt, finding that there was no basis for that interpretation. In *Great-West*, the United States again urged the Court to create an expansion of the equitable remedies under Section 502(a)(3), and was again rebuffed. The Government tried a third time in *Davila/Calad* to persuade the Court to create ERISA damage remedies that Congress did not intend, and once more did not succeed. Petitioner has not offered any new or better arguments than did the Solicitor General.

> that it is not for us to decide the best ERISA remedial scheme.

Id. at 322-23 (citations omitted).

Within the last year, at least four more Circuit Court decisions have been issued affirming the unavailability of monetary relief under Section 502(a)(3). *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006) (affirming District Court dismissal of the Petitioner's Section 502(a)(3) claim on the grounds that it was a disguised Section 502(a)(1)(B) claim, and that monetary relief — damages — is not a remedy available under Section 502(a)(3)); *Knieriem v. Group Health Plan, Inc.*, 434 F.3d 1058, 1063 (8th Cir. 2006) ("Knieriem seeks monetary relief that does not constitute 'other appropriate equitable relief' under section 1132(a)(3)(B)."); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 104 (2d Cir. 2005) (relief characterized as "restitution" was legal, and not equitable, in nature; "[w]e decline this invitation to perceive equitable clothing where the requested relief is nakedly contractual."); *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064, 1076 (9th Cir. 2005) (relief not available under 502(a)(3) because "the only remedy sought is money").

Petitioner's primary argument in favor of allowing a damages remedy under ERISA centers on a purported exception to traditional equity remedial principles. Under those principles, this Court has ruled, money damages were not considered an appropriate remedy in equity, as such damages were the quintessential *legal* remedy. *Mertens*, 508 U.S. at 255 ("Money damages are, of course, the classic form of *legal* relief.") Petitioner contends, however, that there was one exception to this otherwise blanket prohibition that this Court overlooked. This exception applied to the circumstance in which no adequate legal remedy existed. (Pet.'s Br. 11-12.) In that instance, the equity courts could award damages if that were the only means by which to achieve a just result. *Id.*

Notably, Petitioner does not anywhere mention that there is readily available a complete remedy for the allegedly injurious

acts complained of in this case: a suit for benefits due under Section 502(a)(1)(B). Nor does he explain why his claimed exception to the equity principle that damages are not an available form of relief should even apply here to a claimant who sat on his rights and failed to obtain the care that, assertedly, would have prevented the very injuries for which damages are sought.

Petitioner further predicates his argument on the contention that Congress incorporated the common law of trusts into ERISA, and that monetary recoveries were available under that body of law. While it is true that ERISA incorporates many trust law concepts, Congress did not import *all* principles of trust law wholesale into ERISA. This is because while some trust law principles are applicable in a statutory employee welfare plan context, many others are not. The very authority cited by Petitioner in support of this argument concedes that this is the case.

> I do not mean to say that ERISA simply transposes trust law. To the contrary, *ERISA omits large swaths of traditional trust law* that are inapplicable to pension and employee benefit trusts. For example, having originated as a branch of the law of donative transfers, the law of trusts has been particularly attuned to the problems associated with successive estates (commonly life and remainder interests). By contrast, pension and employee benefit plan trusts are commercial arrangements arising from the employment relationship. *Congress had no need in ERISA to carry over doctrines of trust law that speak mainly to intrafamilial wealth transfer.* Likewise, structural differences between the private gratuitous trust and the employee benefit plan caused ERISA to depart from trust law in various ways.

Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103

Colum. L. Rev. 1317, 1327 (2003) (emphasis added). *See also Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250 (2000) ("The common law of trusts . . . offers a '*starting point* for analysis [of ERISA] . . . [unless] it is inconsistent with the language of the statute, its structure, or its purposes"[14]) (citing *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999)) (emphasis added); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) ("ERISA's legislative history confirms that the Act's fiduciary responsibility provisions codif[y] and mak[e] applicable to [ERISA] fiduciaries *certain principles* developed in the evolution of the law of trusts.") (citing H. R. Rep. No. 93-533, p. 11 (1973)) (emphasis added) (internal citations and quotations omitted); *Donovan v. Mazzola*, 716 F.2d 1226, 1231 (9th Cir. 1983) ("in enacting ERISA *Congress made more exacting the requirements of the common law of trusts* relating to employee benefit trust funds") (citing *Sinai Hosp. of Baltimore v. Nat'l Benefit Fund for Hosp. & Health Care Employees*, 697 F.2d 562, 565 (4th Cir. 1982)) (emphasis added).

Petitioner argues that this Court, when it decided *Mertens*, wrongly disregarded the damages remedy provided by equity courts that he has discovered when it declined to craft a damages remedy under ERISA Section 502(a)(3). While there are a numerous flaws in Petitioner's argument, one is dispositive. That flaw is that his circumstances do not satisfy the predicate condition for an award of damages under his newly uncovered exception. The predicate condition of this exception is not satisfied here because Petitioner has always had a clear and express remedy for a wrongful denial of coverage of a claimed benefit. That remedy is Section 502(a)(1)(B). This case, therefore, does not require the Court to examine the issue whether it overlooked certain equitable remedies when it decided *Mertens*. Similarly, the Court has no reason to consider the issue

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[14] Here the common law of trusts as espoused by Petitioner is directly inconsistent with the provisions of ERISA Section 502(a)(1)(B).

whether courts of equity in fact provided damages as a form of relief on the basis of principles of equity and not by reason of their adoption of law court remedies.

There is further reason why this case does not require the Court to again examine the meaning of the term "equitable remedy." Even if Petitioner's analysis were sound that damages were a remedy purportedly available in courts of equity that was not imported from the courts of law, a damages remedy still would not be available under ERISA. This is because, as shown immediately hereafter, Congress clearly determined that damage remedies would not be available under ERISA.

E. This Court Has Already Determined That Congress Expressly Rejected Damages as an Available Remedy Under Section 502(a)(3).

Congress did not forget to provide for a damages remedy under ERISA, nor is the lack of any reference to such a remedy in Section 502 the result of negligent legislative draftsmanship.[15] An express congressional intent not to provide a damages remedy is clearly documented in the legislative history of the statute. That history reveals that, while an early version of the statute contained a provision for "legal or equitable" relief, described in both the Senate and House Committee Reports as authorizing "the full range of legal and equitable remedies

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[15] *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-48

> "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. . . . In contrast to the repeatedly emphasized purpose to protect contractually defined benefits, there is a stark absence – in the statute itself and in its legislative history – of any reference to an intention to authorize the recovery of extracontractual damages."

(Emphasis added).

available in both state and federal courts,"[16] in the bill passed by the House of Representatives and ultimately adopted by the Conference Committee, *the reference to legal relief was deleted.*

Thus, when drafting ERISA, Congress crafted specific enumerated remedies – it did not simply import preexisting remedies from trust law. The remedial provisions in Section 502(a) were carefully crafted to provide recourse for individual participants in Section 502(a)(1), for the plan itself in Section 502(a)(2), and to address fiduciary conduct that affects all plan participants in Section 502(a)(3). Only Section 502(a)(1) is designed to provide relief for injuries to individual participants. Petitioner may lament the unavailability of "make-whole" relief to individual participants under Section 502(a)(3), but he cannot dispute that relief for individual participants' injuries is not the purpose of that statutory provision. Nor can he sensibly dispute that Section 502(a)(1)(B) is the clearly defined remedy for wrongful benefit denials. Section 502(a)(3) is not a supplement to 502(a)(1)(B) – these are distinct statutory provisions with distinct and unique purposes and, as explained above, are mutually exclusive.

To construe these two provisions otherwise would violate the statutory construction doctrine known as "expressio unius-est exclusio alterius." Pursuant to this doctrine, where a statutory provision expresses a single purpose, is made expressly applicable to a single subject, or provides for a specific remedy, all other purposes, subjects and remedies are deemed to be excluded from the effects or compass of the provision. *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003) (explaining that the doctrine has force when items expressed are "members of an associated group or series, justifying the inference that items not mentioned were excluded by deliberate choice, not inadvertence"); *United States v. Vonn*, 535 U.S. 55, 65 (2002)

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[16] *See* H.R. Rep. No. 93-533, at 17 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655; S. Rep. No. 93-127, at 35 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871.

("expressing one item of [an] associated group or series excludes another left unmentioned"); *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81 (2002) (regulation held invalid because it supplemented existing remedial scheme set by Congress in statute and decision by Congress to provide for one remedy indicates that it did not intend for the creation of any others).

While ERISA is grounded in common law principles drawn from trust law and equity, it is nonetheless a statutory regime in which Congress expressed its intentions to protect both plan participants and ERISA plans themselves. Congress thus constructed a remedial scheme designed to achieve both of these purposes. Petitioner has pursued a fruitless string of appeals seeking a judicial interpretation that would radically depart from established precedent and the express intent of ERISA itself. If new remedies are to be grafted onto ERISA's existing remedial scheme, it will be up to Congress to undertake that task. Petitioner's quixotic quest to obtain that result through the courts should end here.

CONCLUSION

Petitioner has failed utterly to provide the Court with any reason to grant his Petition, as this case does not involve issues in which conflicts exist in the lower courts, and it does not present any unresolved or significant questions of law for which the lower courts need guidance. For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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(4)

No. 06-614

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

Petitioner,

—against—

MERIT BEHAVIORAL CARE CORPORATION, SATI AHLUWALIA, M.D. and EMPIRE BLUE CROSS AND BLUE SHIELD,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITIONER'S REPLY BRIEF

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TABLE OF CONTENTS

	Page
Respondents' Briefs Demonstrate Why Certiorari Should Be Granted	1
Point I	
Limiting Beneficiaries to District Court Injunction Actions Under ERISA § 502(a)(1)(B) In Order to Obtain Prescribed Medical Treatment Is A Punitive and Wholly Unrealistic Option	2
Point II	
The Majority in *Mertens* Carefully Limited Its Application to a "Nonfiduciary Actuary"; The Holding Has No Direct Binding Effect on Cases Like This One Involving a Fiduciary's Violation of Statutory Duties and of the Plan Itself	4
Point III	
The District Court Expressly Rejected Merit's Argument on Bankruptcy Discharge; Merit Did Not Cross-Appeal From That Ruling And the Issue Is Not Before the Court	8
Conclusion	10

TABLE OF AUTHORITIES

	Page
Cases	
Aetna v. Davila, 542 U.S. 200 (2004)	7
Mertens v. Hewitt, 508 U.S. 248 (1993)	Passim
DiFelice v. Doe, 346 F.3d 442 (3d Cir., 2003)	2-3
Statutes and Regulations	
ERISA § 502(a)(1)(B)	Passim
ERISA § 502(a)(3)(B)	3, 6, 10
F.R.Civ.P. Rule 12(b)	8-9

I

RESPONDENTS' BRIEFS DEMONSTRATE WHY CERTIORARI SHOULD BE GRANTED

This Reply Brief is submitted by Petitioner Eric Rubin-Schneiderman in response to new points raised in the briefs of Respondents Merit and Empire. The Reply refutes three points:

1. The argument by both Respondents that when Eric Rubin-Schneiderman was denied in-patient care he was obligated to immediately institute a Federal injunction lawsuit under ERISA § 502(a)(1)(B) [Merit brief Point I E (p.16); Empire brief Points II A (p.8) and II C (p.17)].

2. Respondents' overstatements of the *stare decisis* effect of the *Mertens* decision [Merit brief Points I A (p.7) and I B (p.8); Empire brief Points I (p.7) and II D (p.21) and II E (p.26)].

3. Merit's inaccurate statement concerning the lower courts ruling on the defense of bankruptcy discharge [Merit brief Point III (p.20)].

Neither Respondent disputes the accuracy of Petitioner's research discovery that a fundamental premise of Equity Jurisprudence – going back at least to 1737 – was that "a Man is bound in Equity not only to perform his Engagements, but also to repair all the Damages that accrue naturally from the Breach of them." (Petitioner, p. 15)

POINT I

LIMITING BENEFICIARIES TO DISTRICT COURT INJUNCTION ACTIONS UNDER ERISA § 502(a)(1)(B) IN ORDER TO OBTAIN PRESCRIBED MEDICAL TREATMENT IS A PUNITIVE AND WHOLLY UNREALISTIC OPTION

Merit's and Empire's argument that young Eric Rubin-Schneiderman should have engaged attorneys to prepare and file a Federal Court injunction action when Merit denied him in-patient care for his mental health condition is totally unrealistic. Such an injunction proceeding is neither an adequate nor available remedy on these facts. Any experienced member of the New York bar is well aware of the cost of engaging litigators in that City, particularly for a case involving motions and briefs in a novel and complex area of the law, not to mention the delays inherent in the process. The zeal and determination of Merit's and Empire's counsel in their opposition to the beneficiary's claim in this very case is proof of what a beneficiary could expect in an injunction proceeding under Section 502(a)(1)(B).

A realistic initial retainer for qualified counsel to seek a Federal Court preliminary and final injunction, plus the inevitable appeal if the injunction is granted, is probably at least $25,000 or $50,000. These are not services provided by the Legal Aid Society, and certainly not a task for a *pro se* litigant, particularly one suffering from a debilitating psychiatric illness.

Judge Becker's concurring opinion in *DiFelice v. Doe*, 346 F.3d 442,459 (3d Cir., 2003) puts the injunction option in perspective:

> [P]recious few lawyers would be willing to undertake a horrendously complex cast of uncertain outcome when the greatest potential reward is merely provision of the care that had been contractually promised. Without contingency fees, participants in the midst of medical crises are completely at the mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where – as with Mr. DiFelice – the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participants' malady.

In its brief, Merit is able to cite only three successful cases brought under § 502(a)(1)(B) (Merit br. p. 17). The facts in those cases are significant – one sought to pre-certify high dosage chemotherapy, another, a bone marrow transplant – life-and-death situations where cost is presumably no object. To suggest that this same high-cost legal proceeding was an available remedy that could and should be used to obtain short-term mental health treatment is naive at best, and the height of cynicism at worst. Congress certainly could not have decided to force beneficiaries to be limited to such a costly and uncertain remedy. Moreover, an injunction action against Merit and Empire would still leave the claim for relief against Dr. Ahluwalia -- herself a fiduciary -- with no remedy other than § 502(a)(3)(B).

POINT II

THE MAJORITY IN *MERTENS* CAREFULLY LIMITED ITS APPLICATION TO A "NONFIDUCIARY ACTUARY"; THE HOLDING HAS NO DIRECT BINDING EFFECT ON CASES LIKE THIS ONE INVOLVING A FIDUCIARY'S VIOLATION OF STATUTORY DUTIES AND OF THE PLAN ITSELF

The majority in *Mertens* limited the applicability of that decision to the case before it, on facts clearly distinguishable from this case. Note how carefully the majority circumscribed the decision in the very opening sentence of its opinion:

> The question presented is whether a *nonfiduciary* who knowingly participates in the breach of a fiduciary duty imposed by the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 832, as amended, 29 U.S.C. § 1001 [*250] *et seq.*, is liable for losses that an employee benefit plan suffers as a result of the breach.
>
> (508 U.S. 248 at 249) (Emphasis added.)

In the present case, the defendants are all alleged to be *fiduciaries* under the plan (Complaint pars. 4 and 8, A-11-12). As the *Mertens* majority Court was careful to point out, the facts there were exactly the opposite:

> The Court of Appeals decided that respondent was not a fiduciary, see 948 F.2d at 610, and petitioners do not contest that holding. Lacking equivalent provisions specifying the nonfiduciaries as potential

defendants, or damages as a remedy available against them, petitioners have turned to § 502(a)(3), 29 U.S.C. § 1132(a)(3), which authorizes a plan beneficiary, participant, or fiduciary to bring a civil action:

> "(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan."

See also § 502(a)(5), 29 U.S.C. § 1132(a)(5) (providing in similar language, for civil suits by the Secretary based upon violations of ERISA provisions). Petitioners contend that requiring respondent to make the Kaiser plan whole for the losses resulting from its alleged knowing participation in the breach of fiduciary duty by the Kaiser plan's fiduciaries would constitute "other appropriate equitable relief" within the meaning of § 502(a)(3).

We note at the outset that it is far from clear that, even if this provision does make money damages available, it makes them available for the actions at issue here. It does not, after all, authorize "appropriate equitable relief" for the purpose of "redress[ing any] violations or...enforc[ing] any provisions" of ERISA or an ERISA plan. No one suggests that any term of the Kaiser plan has been violated, nor would any be enforced by the

> requested judgment. 508 U.S. 248 at 253 (Emphasis added.)

The logical explanation for a difference between holding a *nonfiduciary* and holding a *fiduciary* liable for compensatory damages under § 502(a)(3)(B) was explained by the *Mertens* majority in the final paragraph of the majority opinion:

> The text that we have described is certainly not nonsensical; it allocates liability for plan-related misdeeds in reasonable proportion to respective actors' power to control and prevent the misdeeds. Under traditional trust law, although a beneficiary could obtain damages from third persons for knowing participation in a trustee's breach of fiduciary duties, only the trustee had fiduciary duties. See 1 Scott & Fratcher § 2.5, p. 43. ERISA, however, defines "fiduciary" not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan, see 29 U.S.C. § 1002(21)(A), thus expanding the universe of persons subject to fiduciary duties – and to damages – under § 409(a). Professional service providers such as actuaries become liable for damages when they cross the line from adviser to fiduciary; must disgorge assets and profits obtained through participation as parties-in-interest in transactions prohibited by § 406, and pay related civil penalties, see § 502(i), 29 U.S.C. § 1132(i) or excise taxes, see 26 U.S.C. §§ 4975; and (assuming nonfiduciaries can be sued under § 502(a)(3)) may be enjoined from participating in a fiduciary's breaches, compelled to make restitution, and subjected to other equitable decrees. All that

> ERISA has eliminated, on these assumptions, is the common law's joint and several liability, for *all* direct and consequential damages suffered by the plan, on the part of persons who had no real power to control what the plan did. Exposure to that sort of liability would impose high insurance costs upon persons who regularly deal with and offer advice to ERISA plans, and hence upon ERISA plans themselves. There is, in other words, a "tension between the primary [ERISA] goal of benefiting employees and the subsidiary goal of containing pension costs." *Alessi v Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515, 68L.Ed.2d 402, 101 S.Ct. 1895 (1981); see also *Russell*, 473 U.S. at 148, n. 17. We will not attempt to adjust the balance between those competing goals that the text adopted by Congress has struck.
>
> (508 U.S. 248 at 262) (Emphasis added.)

Note the majority's reservation in the underscored language: "...even if this provision does make money damages available...." Plainly the Court has left the door open for the Court now to hold that money damages are available to a plan beneficiary harmed by a fiduciary's breach of the statute or by violation of the plan. Both of those breaches are alleged in this case. (See Complaint pars. 21-33 A-15-18)

It is also worth noting that when the U.S. Department of Labor raised the possibility of equitable damages in *Aetna v. Davila*, the Supreme Court did not say that possibility was foreclosed by *Mertens* (as both Respondents argue), but instead indicated that the Court's mind is still open on the question:

> The United States, as *amicus*, suggests that some individuals in respondents' positions could possibly receive some form of "make-whole" relief under ERISA §502(a)(3).*** However, after their respective District Courts denied their motions for remand, respondents had the opportunity to amend their complaints to bring expressly a claim under ERISA §502(a). Respondents declined to do so; the District Courts therefore dismissed their complaints with prejudice.*** Respondents have thus chosen not to pursue any ERISA claim, including any claim arising under ERISA §502(a)(3). The scope of this provision, then, is not before us, and we do not address it.
>
> (542 U.S. 200, at 221, fn.7.)

POINT III

THE DISTRICT COURT EXPRESSLY REJECTED MERIT'S ARGUMENT ON BANKRUPTCY DISCHARGE; MERIT DID NOT CROSS-APPEAL FROM THAT RULING AND THE ISSUE IS NOT BEFORE THE COURT

Merit states an unfortunate half-truth in its brief (at page 22):

> "Neither the District Court nor the Second Circuit below considered this [bankruptcy discharge] issue in dismissing Petitioner's Complaint."

In fact, Merit's counsel, Mr. Cooperman, expressly raised the bankruptcy issue before Judge Hellerstein in open court on the record, and the Judge rejected it as not a

proper ground for a motion to dismiss under Rule 12(b)(6). Here is the key portion of Mr. Cooperman's argument and the District Judge's ruling as they appear in the transcript of the argument on October 11, 2005:

> MR. COOPERAMAN: Very briefly, your Honor. One other issue, which we brought which is different than ERISA is the fact this case has now been five years. Since that time my client Merit has gone into bankruptcy and this claim specifically has been expunged during the bankruptcy proceedings. There is a Merit entity, but it is black letter law which we cited –
>
> THE COURT: That is also an issue that you will have to raise in an answer. Discharge of bankruptcy is an answer and you have to set it up and I am not reaching that.
>
> MR. COOPERMAN: Very well, your Honor.
>
> THE COURT: I am going [to] decide this purely under ERISA, and whether or not Mr. Seymour has a claim for relief.
>
> MR. COOPERMAN: Thank you, your Honor.
>
> (Transcript, Oct. 11, 2005, pp. 13-15.)

The Judge's ruling was absolutely correct under F.R.Civ.P. Rule 12(b). Merit did not appeal from Judge Hellerstein's ruling and may not raise the point here. If the complaint is reinstated, Merit can plead its bankruptcy discharge defense – which is contested by plaintiff – and it can be dealt with on the merits at that time.

CONCLUSION

We believe this is the first case to reach this Court that squarely presents the question whether § 502(a)(3)(B) permits compensatory damages to a beneficiary as an equitable make-whole remedy for direct fiduciary violations of duties prescribed in the statute and fiduciary violations of the plan itself.

No Supreme Court decision has squarely ruled on the available equitable remedy for such violations – not *Mertens, Great-West, Varity* or *Davila.* If certiorari is granted, this will be the case that first determines that question. It is a federal issue of major importance, determining whether individual employees and their families will be given a fair chance to stand up against health insurers and HMOs who deny them needed medical care in bad faith, when such care is covered by their plans and prescribed by their treating physicians.

That is the compelling reason for granting certiorari in this case.

Respectfully submitted,

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